Volume 5

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE JOSEPH C. SPERO, MAGISTRATE JUDGE

DAVID AND NATASHA WIT, et al.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	**No. C 14-2346 JCS**
	)	
UNITED BEHAVIORAL HEALTH,	)	
	)	
Defendant.	)	
	)	San Francisco, California
		Tuesday, October 24, 2017

TRANSCRIPT OF PROCEEDINGS

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I N D E X

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E X H I B I T S

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P R O C E E D I N G S

---000---

THE CLERK: Okay. We're calling.

Case Number is C 14-2346, Wit/Alexander versus UnitedHealthcare Insurance Company. And just a reminder that this 14-5337 has been consolidated into the Wit action.

THE COURT: Okay. Good morning, everyone.

MR. RUTHERFORD: Good morning, Your Honor.

MS. REYNOLDS: Good morning, Your Honor.

Just very briefly before we begin, I wanted to take a moment just to introduce to the Court another of our plaintiffs who was here yesterday and is here this morning, Cecilia Holdnak. And Linda Tillitt is in the room as well.

THE COURT: Okay. Welcome.

MS. REYNOLDS: And the plaintiffs call Francis Bridge by video.

THE COURT: Okay.

(Video was played but not reported.)

THE COURT: Fabulous. That's great television.

MS. REYNOLDS: At this time the plaintiffs call Eric Rockswold also by video.

THE COURT: Do you want to make a motion as to 290 and 291.

MS. REYNOLDS: Thank you, Your Honor. Plaintiffs move

Exhibits 290 and 291 into evidence.

MR. BUALAT: No objection, Your Honor. Those are subject to the sealing order from yesterday --

THE COURT: Okay.

MR. BUALAT: -- correct?

THE COURT: Whatever I ordered counts, yes.

MR. BUALAT: Great. Thank you.

THE COURT: And, yes, they're admitted.

(Trial Exhibits 290 and 291 received in evidence)

THE COURT: So who do we have?

MS. REYNOLDS: Eric Rockswold is the next witness.

(Video was played but not reported.)

MR. ABELSON: Your Honor, these two documents are subject to UBH's order to seal. The Court sealed them so we've provided hard copies to Your Honor in a binder. UBH asked that they not be displayed, Your Honor.

THE COURT: Okay. Karen, can I see them?

Are these the right exhibit numbers?

MR. ABELSON: In the new exhibits, it's 564 and --

THE COURT: Well, which is 23?

MS. REYNOLDS: 812.

THE COURT: It's 812. Okay. Got it. Thank you.

(Video was resumed playing but not reported.)

MS. REYNOLDS: Your Honor, plaintiffs move to admit Exhibits 564 and 812 into evidence.

MR. BUALAT: No objection, Your Honor.

THE COURT: Okay. Those are admitted.

(Trial Exhibits 564 and 812 received in evidence)

MR. ABELSON: Your Honor, just a few loose ends. There are some stipulations the parties have entered that we'd like to move into evidence. First is one that the parties actually signed this morning with respect to the class list. This is Trial Exhibit 896.

So we'd like to move into evidence this stipulation, which lays out some of the fields that, among other things, that Ms. Bridge testified about. So we'd like to move into evidence Trial Exhibit 896, as well as Trial Exhibit 255, which is the underlying class list, and the Court has in electronic form and which the parties have agreed should be filed under seal.

THE COURT: Just hang on a second.

(Pause in proceedings.)

THE COURT: Okay. Any objections?

MS. ROMANO: No objection, Your Honor.

THE COURT: Okay. They're admitted.

(Trial Exhibits 255 and 896 received in evidence)

THE COURT: And which one is filed under seal? The class list?

MR. ABELSON: Yeah. Exhibit 255.

THE COURT: Okay. Those are admitted. 255 is under seal.

MR. ABELSON: And then we'd also like to move into evidence Trial Exhibit 711, which is a stipulation concerning per-member-per-month rates.

THE COURT: Okay.

MR. ABELSON: This document was previously provided to the Court in electronic copy form.

THE COURT: Yes?

MR. BUALAT: Your Honor, we would -- UBH objected to this document in its *Motion in Limine* Number 3 relating to relevance. This is related to per member per month. I assume you're going to overrule the objection.

THE COURT: I think I have.

MR. BUALAT: Plaintiffs -- I'm sorry, Your Honor. Plaintiffs have stipulated to sealing the member-per-month data that is in Exhibit 1. We will be providing the redacted versions. Someone will bring it at lunch so we could -- if that's all right with Your Honor, we'll bring it then.

THE COURT: So portions of 711 will be redacted; right?

MR. BUALAT: Yes, the exhibit.

THE COURT: And sealed.

MR. ABELSON: Thank you, Your Honor.

THE CLERK: So portions of 711 are sealed?

THE COURT: Yes.

THE CLERK: And just let me clarify. 896 is not

sealed?

MR. ABELSON: Correct.

THE COURT: 896 is not sealed.

(Trial Exhibit 711 received in evidence)

MS. REYNOLDS: And at this time plaintiffs rest.

THE COURT: Okay. Onward.

MS. ROMANO: Your Honor, since plaintiffs have rested, UBH brings an oral motion for judgment on partial pleadings -- partial findings -- excuse me -- under Rule 52(c).

I want to present a few of the key issues where plaintiffs have failed to carry their burden. UBH is not raising its right to waive other issues or arguments later in trial, posttrial briefing, on appeal, or in a motion for decertification.

Two primary issues we'd like to raise at this time, Your Honor, is that plaintiffs have not offered any testimony about many of the Coverage Determination Guidelines at issue in this case.

The Coverage Determination Guidelines were used for approximately half of the class members. There's 216 Coverage Determination Guidelines that were admitted into evidence, Exhibits 9 through 224. We have only heard testimony on seven of them, the Custodial Care Guidelines. Those seven are Exhibits 10, 47, 84, 108, 148, 195, and 221.

With the exception of those, there are 216 Coverage

Determination Guidelines that have not been mentioned or discussed other than admitting them into evidence. No testimony about what they say, what they mean, or whether they incorporate any of the language that has been critiqued by plaintiffs' experts with respect to the Level of Care Guidelines at trial.

THE COURT: Okay.

MS. ROMANO: The issue two -- primary issue two, Your Honor, we wanted to raise is that plaintiffs have not carried their burden to prove that the guidelines are inconsistent with each of the plans as a whole.

The only evidence that we saw from plaintiffs with respect to the plans is the testimony and exhibits presented through their summary witness, Ms. Duh, yesterday; but that evidence did not identify instances where -- or they solely identified instances where the plans make reference to particular terms or phrases that counsel asked Ms. Duh to find in the plans.

There was no testimony relating to what those plans mean, what the provisions mean that Ms. Duh mentioned or how they fit into the plans as a whole or whether the guidelines are inconsistent with the plans.

THE COURT: Okay.

MS. ROMANO: Because of these failings, Your Honor, plaintiffs have not presented class-wide common proof that UBH breached a fiduciary duty or violated the terms of all of the

class members' ERISA plans that are at issue in this case.

And, in addition, Your Honor, I'd like to state for the record that UBH also believes plaintiffs have failed to prove their claims as a matter of law for several other reasons, reasons that have been raised before; namely, that plaintiffs have not offered class-wide proof that any breach of fiduciary duty caused harm to the plaintiffs or class members.

They didn't carry their burden to prove that the alleged flaws in the guidelines that were cited by plaintiffs' experts caused a denial of benefits or otherwise caused any harm to plaintiffs or class members.

And that plaintiffs have not established with the evidence at trial Article III standing for themselves or the class members because they've not made any showing of actual concrete harm to plaintiffs or the class members resulting from any conduct by UBH.

THE COURT: Thank you.

Would you like to respond?

MS. ROMANO: And I'll go ahead and come over here.

MS. REYNOLDS: Your Honor, of course, plaintiffs oppose the motion. Just addressing first the two primary issues that UBH's counsel has raised.

With respect to the Coverage Determination Guidelines, Your Honor, most importantly you'll note that the motion was very carefully limited to a supposed lack of testimony but not

a lack of evidence, and that's because the parties have stipulated as to language that incorporates the LOCGs into the CDGs. That stipulation was entered into evidence on the first day of trial.

THE COURT: What's the exhibit number?

MS. REYNOLDS: Sorry?

MR. ABELSON: 880.

MS. REYNOLDS: 880.

THE COURT: 880.

MS. REYNOLDS: It's Exhibit 880, which is a stipulation between the parties, and in particular in paragraphs 29 and 30, the stipulation addresses the fact that each of the Coverage Determination Guidelines that is listed, which are the Coverage Determination Guidelines in evidence in the case, contains one or more references to one or more Level of Care Guidelines and then there's a specification exactly what that language is. There are various categories and then there's a chart attached to the stipulation that specifies exactly which of those categories of incorporation language appears in each of the CDGs.

And the CDGs further are grouped so that they are corresponding to a particular Level of Care Guidelines year. And so that's also indicated on the stipulated-to chart so that insofar as any particular year's Level of Care Guidelines fall short of generally accepted standards of care and those CDGs

are found to incorporate those Level of Care Guidelines, plaintiffs' argument is that the CDGs are also invalid that fall in that same group.

And if the Court would like, I can discuss further what the specific incorporation language is.

And I'd also just like to note that yesterday there was testimony from Dr. Triana that the CDGs incorporate the LOCGs, and there has been testimony as to the fact that the testimony and documentary evidence as to the fact that the CDGs and the LOCGs are highly interdependent and need to be kept in sync.

With respect to the second issue, whether or not plaintiffs have proven that the Level of Care Guidelines are inconsistent with the class members' plans, there has been extensive evidence offered by plaintiffs' expert testimony and documentary evidence to show that the Level of Care Guidelines fall below generally accepted standards of care.

And we have submitted into evidence each one of the class members' plans and a summary witness, Ms. Duh, who testified that each and every one of those plans includes language that refers to generally accepted standards of care. And the plaintiffs' argument is that that language makes it one condition of coverage under each one of the plans that the services be consistent with generally accepted standards of care.

And, further, Ms. Duh, the summary witness, testified that

each and every one of the denials in this case cited to a Level of Care Guideline or Coverage Determination Guideline, which, as the testimony yesterday and the documentary evidence demonstrates, indicates that the Level of Care Guidelines were used in whole or in part as a basis for the denial for each class member's claim.

And we submit that that is sufficient evidence to withstand a motion for partial judgment.

THE COURT: Anything further?

MS. ROMANO: Just quickly on the stipulation, Your Honor. It is not a stipulation showing that all of these Coverage Determination Guidelines incorporate in the language or terms of the Level of Care Guidelines.

A review of paragraphs 20 through -- let's see -- 28 explain what the stipulation is and the multiple types of references or no references to the Level of Care Guidelines that come in through these various Coverage Determination Guidelines.

Some of the Coverage Determination Guidelines merely reference that there will be clinical protocols that are followed. And the chart, which I will just show for Your Honor, shows multiple ways that the Coverage Determination Guidelines do or do not reference Level of Care Guidelines or do or do not include language from the Level of Care Guidelines.

There is no evidence in the record that the language and terms challenged in the Level of Care Guidelines are incorporated into each of these 216 Coverage Determination Guidelines.

THE COURT: Okay. Thank you both.

MS. ROMANO: Thank you.

Your Honor, United Behavioral Health would like to call Barry Dehlin to the stand, and Ms. Ross will be handling that testimony.

(Pause in proceedings.)

THE CLERK: Good morning. Can you raise your right hand before you're seated?

BARRY WILLIAM DEHLIN,

called as a witness for the Defendant, having been duly sworn, testified as follows:

THE WITNESS: I do.

THE CLERK: Thank you.

Please go ahead and have a seat. Make yourself comfortable and make sure that you speak clearly into the microphone for our court reporter.

And could you please just state your full name for the record and spell your last name.

THE WITNESS: Sure. My name is Barry William Dehlin. Last name is D-E-H-L-I-N.

THE CLERK: Thank you.

DIRECT EXAMINATION

BY MS. ROSS:

Q. Good morning, Mr. Dehlin.

A. Good morning.

Q. Can you briefly describe your educational background?

A. Yes. I had university at Princeton University, and I have a master's degree from the University of Michigan School of Public Health.

Q. Who is your current employer?

A. UnitedHealthcare.

Q. How long have you worked for United?

A. Since 2003. So 14 years.

Q. Can you briefly describe for the Court your job title and responsibilities?

A. My title is director of product strategy, and I work with a lot of different parts of UnitedHealthcare's product organization supporting them with background information, market research, analytics data, best practices, that type of thing.

Q. And have you been in a product management role the full 14 years that you've worked for United?

A. Yes, I have.

Q. And what do you mean when you say "product"?

A. Right. So a product when you're talking about health benefits, the core of it is going to be the benefit coverage

that we're responsible for. Around those benefits, we often wrap many other services: Tools for consumers, website, things to help them understand how much different types of care might cost, services that help manage the health of a population. So there are a variety of other services like that.

Q. So is a product the same as a plan?

A. They're pretty close to the same thing, yes.

Q. Who are United's customers?

A. We have a ton of different types of customers, from individuals who buy insurance from us just for themselves or their family, but more frequently employers of all types -- very small employers, medium-to-large-size employers -- and then a variety of other non -- you know, other organizations like union organizations and things like that. So a huge diversity.

Q. Talking about United's employer customers, what do employers hire United to do?

A. Our employers are looking -- our employer customers, I should say, are looking for us to do a variety of things for them. The most important is to make sure that their employees have a set of benefits that, you know, provide them the coverage they want.

To do that, we have to do a variety of things. We contract with providers, hospitals, physicians, and others, to create a network that those folks can seek care from. We

receive claims, review them. When there are covered services under the plan, we pay them. So we adjudicate all of those claims.

We provide a lot of those services that I mentioned earlier, services for their employees. We provide, you know, population health services. So employers are looking for all of those things from us.

And then some employers are looking for us to bear the risk of, you know, unexpectedly high healthcare costs.

Q. You work for UnitedHealthcare. Are you familiar with United Behavioral Health or UBH?

A. I am.

Q. Is there a relationship between UnitedHealthcare and UBH?

A. Yes. We are both sister companies within the larger umbrella company called UnitedHealth Group.

Q. And what does UBH do?

A. UBH is an organization that is -- has expertise in behavioral health, mental health substance abuse services; and for us but also for other of their customers outside of UnitedHealth Group, they provide many of the types of things that I just mentioned but focus on behavioral health.

So they create a network and contract with providers. They receive claims, evaluate those claims, pay them when there are covered services. They do other similar population health management. They provide consumer tools. So they do all of

those things for us and for their other customers.

Q. And if someone is unhappy with a decision that UBH makes about whether they get coverage for behavioral health treatment, do the plans allow them to appeal?

A. They do.

Q. Do you understand that this case is about behavioral health benefit plans administered by UBH?

A. Yes.

Q. And are you familiar with the plans in this case?

A. Yes, I am.

Q. How are you familiar with the plans?

A. I have reviewed many of the plans, not word for word but some -- certainly a lot of the sections that some are critical that have been put together in, you know, the fairly voluminous summaries that we have.

Q. And we'll get to those summaries shortly. Do you understand that the plans that you reviewed in this case for the plaintiffs and the sample members are just a subset of the larger universe of plans involved in this case?

A. I do understand that.

Q. How many different benefit plans does United offer?

A. Almost too many to count. When it comes to a lot of different customers, we have different states will have different plans, thousands, tens of thousands. I mean, just a huge number.

Q. And does United Behavioral Health administer the behavioral benefits for all of those plans?

A. Probably not all but the vast, vast majority. There will be some instances where a large group may choose to outsource their behavioral health services and receive them from a different behavioral health vendor; but for the vast majority of what we do, yeah, UBH is involved.

Q. Are all of those plans the same?

A. No.

Q. Can you describe for the Court some of the variations in the plans that UnitedHealthcare offers to its customers and that UBH administers with respect to behavioral health benefits?

A. Sure. So our products and plans can vary in a lot of different ways. I alluded to one earlier, which is some of our plans are fully insured plans where a customer is looking for financial certainty and we provide, you know, that certainty by bearing the risk.

There are some plans that are self-funded where the customer will take on more risk themselves.

There are plans that are for customers who are looking for a very generous or rich set of benefits. So there will be, you know, perhaps some additional covered services, very low cost sharing, no deductibles, low copays.

To the contrary, there are plans for customers who are

much more price sensitive and are looking for leaner things. So perhaps a fewer -- several fewer covered services and much more significant cost sharing.

And then the other services that we wrap around it can vary quite a bit, some from plan to plan as well.

Q. Could the plans also differ with respect to appeal rights under the plans?

A. They could.

Q. And could state law also affect the terms of a plan?

A. Absolutely, for fully insured plans.

Q. Are you familiar with the term "Certificate of Coverage," which is sometimes shortened to COC?

A. I am.

Q. And what is a COC?

A. A Certificate of Coverage is something that's in conjunction with a fully insured plan, describes our responsibilities to our members, the consumers, and to some extent some describes their responsibilities to us.

Q. And does it define the scope of benefits that are available under that plan to its members?

A. Among many other things, yes, it does that.

Q. What about the term "summary plan description" or SPD? Are you familiar with that term?

A. I am.

Q. What is an SPD?

A. An SPD will serve pretty much the same role as a COC, or a Certificate of Coverage, but in the context of self-funded plans.

Q. Let's start with fully insured plans. What is a fully insured plan?

A. A fully insured plan is where an employer is looking for financial certainty in terms of how much they will pay. So they will have a premium, according to that plan, and that will be the amount they pay typically on a monthly basis; and there is no risk, no chance that they will pay more than that. So they have financial certainty. And if there are higher than expected healthcare usage and higher than expected costs, we end up paying, you know, that extra amount.

Q. What is UBH's role with respect to fully insured plans?

A. UBH administers -- or for mental health and substance abuse services will, you know, administer those services for us for a variety of fully insured plans, but their function is really no different for fully insured or self-funded.

Q. And what do you mean by "no different"?

A. They for -- whether it's fully insured or self-funded, there is a set of defined benefits, and they are focused on adjudicating those benefits; and really our risk arrangement with our customer doesn't come into play with how they do their -- how they play their role in any way.

Q. You're referring to how they administer benefits?

A. Correct.

Q. Does it affect whether UBH bears risk with respect to whether a plan is fully insured or self-insured?

A. No. Our risk arrangements with our customers has nothing to do with, you know, how UBH -- with any risk arrangement they may have.

Q. How does United determine what premium to charge the customer of a fully insured plan?

A. So there's a lot that goes into that, and the answer will be different depending on state laws, depending on the type and size of customer; but, in general, it starts with estimating, you know, the medical costs for that group; or perhaps for some pool of people if we can't focus on that employer, once we have an estimate of medical costs, we will add in a certain amount for administrative expenses, and then we will also add a certain amount for margin or profit. The sum of those things is the premium.

Q. Does UBH -- or does United review and, if needed, adjust the premiums to account for changes in the anticipated cost of providing or administering fully insured benefit plans?

A. We would, to the extent we can according to law.

Q. Now, what is a self-funded plan?

A. A self-funded plan is a situation where an employer is willing to take some risk. So we will certainly give them our best guess, our expert guess, at how much their population will

spend, but -- and so they will know that.

If -- if the actual experience is higher than expected, they will actually pay the extra. If the actual experience is lower than expected, they will pay less than expected. They bear the risk and they're only paying us for our administrative services.

Q. Do all of the plans offer the same scope of benefit coverage?

A. They do not.

Q. So who decides what benefits will be included in any given plan?

A. It depends on the type of plan. So for fully insured plans, we typically have filed a variety of different plans with state regulators, and those will, you know, be the amount -- the benefits that are used. That's, of course, informed over time by what customers have requested and by state law and other rules.

For self-funded benefits, we typically have a starting point, but self-funded customers and typically larger customers have the flexibility and often make changes to those things. We try to accommodate those changes to the extent that we have the ability to do so, that it's legal to do so.

Q. Does UBH play a role in setting the behavioral health benefit terms for either fully insured or self-insured plans?

A. They have some influence. So they are our behavioral

health experts, so we certainly look to them for expertise for our fully insured plans and what should be covered.

For self-funded plans, they also have shaped sort of our default starting point; but, again, customers -- self-funded customers do have the right and often do vary or diverge from that.

Q. And you mentioned that cost sharing can vary by plans; is that right?

A. That's correct.

Q. What did you mean by cost sharing?

A. Cost sharing is basically a situation where the cost for any given service is split between the insurance company and the consumer.

For any given service, there will -- if it's a network, there will typically be a contracted rate depending on the plan, how much the consumer has spent on that plan, to determine whether they've met their deductible and other things. The consumer may pay more or less.

The cost sharing is basically the consumer's responsibility out of any of the cost of any specific service.

Q. So that would include things like copays and deductibles and coinsurance?

A. Yes, it would.

Q. All right. Is a plan typically effective for a specific period of time or is it open-ended?

A. Typically effective for one year.

Q. And do state regulators approve the plan terms before you offer the plans to customers?

A. For fully insured plans, yes, they do.

Q. What about for self-insured plans?

A. Self-insured plans state regulators have no role.

Q. Okay. Let's look at some of the plans in this case. Mr. Dehlin, you should have three binders down to your left, I think, sitting on the floor. We'll start with the one that's labeled Volume 1.

And if you could turn to Trial Exhibit 225, which has already been admitted into evidence.

Mr. Dehlin, do you recognize Trial Exhibit 225?

A. I do.

Q. What is it?

A. This is a Certificate of Coverage for an employer called Granite Construction, that was in effect January of 2013.

Q. Is this a fully insured plan or self-funded plan?

A. This Certificate of Coverage represents a fully insured plan.

Q. Who is responsible for administering and paying benefits under this plan?

A. We are; United Behavioral Health.

Q. And how about for behavioral health benefits? Who's responsible for administering and paying those benefits?

A. For behavioral health in general, as we've talked about, we've delegated that responsibility and agreed to that with UBH.

Q. And does this plan provide benefits for all healthcare treatment a member might receive?

A. It does not.

Q. If I can direct your attention to page 0032 of Exhibit 225.

There's a section here called "Your Responsibilities." Do you see that?

A. I do.

Q. About halfway down the page there's a heading that says "Be aware this benefit plan does not pay for all health services."

Do you see that?

A. I do.

Q. So does this plan cover treatment anytime a provider recommends treatment?

A. Not necessarily, no.

Q. How about anytime a provider believes that it is medically necessary for the member to receive that treatment?

A. Not necessarily, no.

Q. Does it cover only the covered health services as defined through this document?

A. Yes.

Q. And are those covered health services also subject to certain exclusions and limitations that would be set out in the plan document?

A. They are.

Q. So if you can turn, now, your attention to page 0009 of Exhibit 225.

At the bottom of that page there's a section with a heading "Mental Health Services and Substance Use Disorder Services."

Do you see that?

A. I do.

Q. And if you turn to page 10, that section continues.

And the final paragraph of that section, I'd like to direct your attention there. It starts: "The Mental Health/Substance Use Disorder Designee."

A. I see it.

Q. It says:

> "The Mental Health/Substance Use Disorder Designee performs utilization review to determine whether the requested service is a covered health service. The Mental Health/Substance Use Disorder Designee does not make treatment decisions about the kind of behavioral healthcare you should or should not receive. You and your provider must make those treatment decisions."

Do you see that?

A. I do.

Q. There's a reference here to "The Mental Health/Substance Use Disorder Designee." Who is that?

A. For this plan, that would be UBH.

Q. So under this plan, does UBH have discretion in performing utilization review to determine whether the requested service is a covered health service?

A. They do.

Q. And if I could turn your attention to page 34, please, of Exhibit 225. This is a section titled "Our Responsibilities."

Do you see that?

A. I do.

Q. What is the purpose of this section?

A. This section describes our responsibilities to the consumers or our members in the context of the plan.

Q. And if I can direct your attention to the section that says "Determine Benefits," which is the top of the Our Responsibilities section.

A. Okay.

Q. Do you see that?

A. I do.

Q. And then about halfway down that section there's a part that starts "We have the discretion to do the following."

A. I see it.

Q. And two bullet points.

And then under that it says:

"We may delegate this discretionary authority to other persons or entities that may provide administrative services for this benefit plan, such as claims processing."

Do you see that?

A. I do.

Q. Has United Healthcare delegated to UBH its discretionary authority under this benefit plan with respect to behavioral health coverage?

A. That's correct.

Q. So looking at the two bullet points above that, is it correct to say now that this means that UBH has the discretion to interpret benefits and the other terms, limitations and exclusions set out in this certificate, the schedule of benefits, and any riders or amendments?

A. That's correct.

Q. Is it also correct, then, that UBH has discretion to make factual determinations relating to benefits?

A. That's correct.

Q. Are there other provisions in the plan that also speak to UBH's discretion to interpret terms and administer benefits?

A. There are.

Q. If I can direct your attention to page 85 of Exhibit 225, please.

And if you look at page 83, you see this is in a section called "Section 8: General Legal Provisions." Do you see that?

A. I do.

Q. And turning to page 85, about halfway down the page there's a bolded section that has a heading "Interpretation of Benefits."

Do you see that?

A. I do.

Q. What is the purpose of this section?

A. This section it's -- points out that we, United Healthcare, or potentially our designee for certain areas, have responsibility and the sole authority to interpret the benefits.

Q. And, again, is this discretion that United Healthcare has delegated to UBH with respect to the administration of mental health and substance use disorder benefits?

A. Yes, it has.

Q. If I can direct your attention back to page 31 of Exhibit 225, to the section titled "Introduction to Your Certificate."

Do you see that?

A. I do.

Q. And the first heading under that says "How to use this document."

Do you see that?

A. Yes.

Q. What is the purpose of this section?

A. This section is to give our consumers a brief overview of how they should think about using this document which is something that's likely to be unfamiliar to them.

Q. And the first sentence here reads:

"We encourage you to read your Certificate and any attached riders and/or amendments carefully."

Why is it important that you read the certificate and any attached riders and amendments carefully?

A. It's important because looking at any one part of this document will not tell you the whole story.

To understand whether a service is a covered benefit, you would need to look at, first off, our definition of covered services. You would need to look at our list of types of services which are covered services. You'd also need to look at exclusions.

And then for some plans you may need to look at things that are added to the end: riders or amendments which, you know, could affect the meaning of the plan.

Q. And if you look at the third paragraph of the "How to Use this Document" section, the one that reads:

"Many of the sections of this certificate are related to other sections of the document. You may not have all of the information you need by reading just one section."

Is that what you were just referring to, Mr. Dehlin?

A. Yes, it is.

Q. And then below that there's a heading that says "Information about Defined Terms."

Do you see that?

A. Yes.

Q. Would you also need to look at how specific terms are defined in the document in order to understand the scope of coverage?

A. You would.

Q. Can you know what is covered by a benefit plan simply by looking at how covered health services are defined?

A. That's a good start, but it's not the end of the story.

Q. Can you know what's covered by a plan simply by looking at the exclusions for a particular type of coverage?

A. Also a very good start, but still not the end of the story.

Q. Okay. So I think you just described a number of steps that you would take to determine coverage. Am I right that you said that the first step would be to look at how covered health services are defined? Is that right?

A. Yes.

Q. So why don't we do that. Let's look at page 90 of Exhibit 225. And at the bottom of page 90, continuing on to page 91, do you see a definition for "Covered Health Services"?

A. I do.

Q. And it starts:

"Covered Health Services: Those health services including services, supplies, or pharmaceutical products which we determine to be all of the following."

Do you see that?

A. I do.

Q. And it's followed by five bullet points; is that right?

A. Yes.

Q. Who is the "we" here in terms of "which we determine to be all of the following"?

A. "We" is United Healthcare.

But with respect to certain areas like behavioral health, it could be a designee that we use to help us adjudicate the benefits.

Q. So do health services or treatment need to meet all five of these criteria for benefits to be paid under the plan?

A. They do.

Q. And looking at the second bullet here, is one of those requirements for covered health services that the -- that UBH determine that the health services are consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines as described below?

A. Yes, it is.

Q. Is it sufficient for coverage that the treatment be

consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines?

A. No. That's one of the requirements, but there's other requirements as well.

Q. So would you also need to determine, for example, looking at the first bullet, that the treatment is provided for the purpose of preventing, diagnosing, or treating a sickness, injury, mental illness, substance use disorder, or their symptoms?

A. Among other things, yes.

Q. And looking at the third bullet, would you also need to determine whether the treatment is not for the convenience of the covered person, physician, facility, or other person?

A. Correct.

Q. And in the fourth, you'd also need to determine whether the treatment is described in the certificate under the covered health services section in the schedule of benefits?

A. Correct.

Q. And the last bullet, would you also need to determine that the treatment is not otherwise excluded under Section 2: Exclusions and Limitations?

A. Correct.

Q. So if you can look at the bottom of -- I'm sorry. And all of those things would need to be true in order for something to

be a covered health service?

A. That's correct.

Q. If you look at the last paragraph of the definition of covered health services, there's a section that begins "We maintain clinical protocols."

Do you see that?

A. I do.

Q. And it reads:

> "We maintain clinical protocols that describe the scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services."

Do you see that?

A. I do.

Q. Does the reference to "clinical protocols" here include UBH's Level of Care Guidelines?

A. It does.

Q. Does it also include UBH's Coverage Determination Guidelines?

A. It does.

Q. And above that you see there are definitions for scientific evidence and prevailing medical standards in clinical practice?

A. I see it.

Q. Sorry, prevailing medical standards and clinical

guidelines. I apologize.

You see that?

A. I do.

Q. Does this section here mean that UBH's Level of Care Guidelines and Coverage Determination Guidelines describe the scientific evidence, prevailing medical standards, and clinical guidelines as those terms are defined here?

A. It means that, you know, they describe the protocols but in the context of supporting the services that are covered in the plan.

Q. Is there any requirement that the plans cover all treatment that falls within the scope of generally accepted standards of care?

A. No.

Q. Can plans limit or exclude benefits even where the treatment is consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines?

A. Yes.

Q. So I believe you testified that the definition of covered health services, I think you said, would be a good place to start, but that you would need to look at other sections of the certificate to know what's covered; is that accurate?

A. It is.

Q. So can you walk us through, at a high level, the steps

that you would take after looking at the definition of covered health services to understand what this plan, particularly Trial Exhibit 225, covers with respect to mental health treatment.

A. Sure. And it is alluded here -- alluded to here as well.

You would want to look in the covered services section which details a number of specific services that are covered under the plan. After that, you would want to look at the exclusion section to make sure that whatever service you're investigating is not -- does not fall under one of the exclusions.

And then, as we mentioned earlier, there could be -- not in every plan, but in some plans there could be riders or amendments that affect those coverages and exclusions.

Q. Would you also need to look at any relevant definitions along the way to understand those provisions?

A. You may.

Q. Would you have to follow, generally, that same process to determine the scope of coverage for substance use disorder benefits under the plan?

A. Yes. Regardless of the service, it would be the same general approach.

Q. And do all of the plans that you reviewed for this case define covered health services the same way that Exhibit 225 defines this here?

A. No.

Q. You testified earlier about self-funded and fully insured plans. Do you remember that?

A. I do.

Q. And for self-funded plans, I believe you testified that the employer has input into crafting the plan's coverage terms. Is that right?

A. They have that right if they choose to exercise it. Some do; some don't.

Q. Would it be fair to say that there's generally more variation in the coverage terms among self-funded plans compared to fully insured plans?

MR. ABELSON: Objection. Leading.

THE COURT: Sustained.

Why don't you ask a non-leading question.

BY MS. ROSS:

Q. Mr. Dehlin, how much variation is there in self-funded plans compared to fully insured plans?

A. Tremendous, you know, additional variation.

Q. Let's turn to Trial Exhibit 2014, which I believe is in Volume 2 of your exhibit binder up there.

Mr. Dehlin, do you recognize Trial Exhibit 2014?

A. Yes.

Q. What is it?

A. This is a summary plan description and SPD for benefits

provided by Delta to their employees.

Q. Is this a self-funded plan?

A. Yes.

Q. Is it one of the sample member plans that you reviewed for this case?

A. Yes.

Q. If I can direct your attention to page 0164 of Exhibit 2014. Let me know when you're there.

Do you see about halfway down the page there's a section that begins "The services and supplies described on the following pages are covered under this plan -- under the plan?"

Do you see that?

A. I do.

Q. What is the purpose of this section?

A. This -- for this SPD is starting to define what the plan will cover.

Q. And there's three bullets. And under that it says:

"These supplies and services must also meet each of the following criteria."

Do you see that?

A. I do.

Q. And are those criteria that need to apply in order for -- for something to be a covered health service under this plan?

A. That's correct.

Q. So the first -- the first criteria there in the first

bullet says:

"They are supported by national medical standards of practice."

So is that a condition of coverage on this plan, that treatment be supported by national medical standards of practice?

A. Yes.

Q. Looking down at the third bullet, reads:

"They are the most cost effective method and yield a similar outcome to other available alternatives."

Do you see that?

A. I do.

Q. Would it be appropriate, under this plan, for the administrator to also consider whether the treatment yields a similar outcome to a different method that may be more cost effective in addition to being supported by national medical standards of practice?

A. It would be appropriate and pretty much required by the terms of the plan.

Q. Let's turn, now, to Trial Exhibit 1555, which is back in Volume 1.

Are you there?

A. I do.

Q. Are you familiar with Trial Exhibit 1555, which was previously admitted?

A. I am.

Q. And what is it?

A. This is a benefit document for PeaceHealth, effective January 2013.

Q. Is this one of the sample plans that you reviewed in this cases?

A. It is.

Q. If I can direct your attention to page 138, please, of Trial Exhibit 1555. Are you there?

A. I am.

Q. And at the bottom of page 138, continuing on to page 139, do you see a definition for "Medically Necessary"?

A. I do.

Q. What is the purpose of this definition?

A. Most plans, including this one, you know, will only cover plans that are medically necessary. This is the definition to help guide folks to help make sure they understand that.

Q. Is one of the conditions for service to be medically necessary under this plan that the treatment be appropriate with regard to standards of good medical practice?

A. That's correct.

Q. Is that the only condition to determine whether treatment is medically necessary?

A. No. There are several others.

Q. And let's look at the fourth bullet, which actually

appears at the top of page 139.

A. Uh-huh.

Q. And that reads:

"The least costly of the alternative supplies or levels of service which can be safely provided to the participant when specifically applied to a medical facility inpatient. It further means that the service or supplies cannot be safely provided in other than a medical facility inpatient setting without adversely affecting the participant's condition or the quality of medical care rendered."

Do you see that?

A. I do.

Q. So in determining whether services -- services for which a member is requesting benefits under this plan are medically necessary, would it be appropriate for the benefit administrator to consider whether this fourth criteria is also met?

MR. ABELSON: Objection, Your Honor. The question is about appropriateness. This expert testimony has not been disclosed as an expert in this case.

THE COURT: Overruled. Proceed.

BY MS. ROSS:

Q. Mr. Dehlin, would it be appropriate for the benefit plan administrator to consider whether this fourth criteria, that

appears on the top of page 139, that the treatment be the least costly of the alternative supplies or levels of service which can safely be provided to the participant?

My question, Mr. Dehlin, is if it would be appropriate for the plan administrator to consider whether that criteria is satisfied in evaluating whether treatment is medically necessary under the terms of the plan at Trial Exhibit 1555.

A. It would be appropriate and also required to faithfully administer the plan.

Q. Let's turn to Trial Exhibit 1622, please, which, I apologize, is now in your second binder again.

Are you there?

A. I am.

Q. Do you recognize Trial Exhibit 1622, which was previously admitted into evidence?

A. I do.

Q. What is it?

A. This is another plan document for a company called KeyCorp Medical. And I apologize. Effective date January 2014.

Q. Is this another of the sample plans that you reviewed for the sample class members in this case?

A. It is.

Q. And let me direct your attention to page 85 of Exhibit 1622, where again the definition of medically necessary appears.

Are you there?

A. I am.

Q. Do you see there are -- says:

"Healthcare services, supplies, or interventions would satisfy all of the following criteria as determined by the plan administrator."

Do you see that?

A. I do.

Q. And then it's followed by eight criteria that are listed below, that are set off by bullet points?

A. That's correct.

Q. Do all eight of those criteria need to be satisfied under this plan for treatment to be medically necessary?

A. That's correct.

Q. And looking at the third bullet, which begins:

"The services or supplies are the most appropriate supply or level of service that is essential to the patient's needs."

Do you see that?

A. I do.

Q. So under this plan, would it be appropriate for the plan administrator to consider whether the requested level of care is the most appropriate level of care that is essential to the patient's needs?

A. Yes.

Q. In looking at the fourth point, fourth criteria here, which begins "For hospital or other facility stays."

Do you see that?

A. I do.

Q. Does that include residential treatment?

A. I'm sorry, it's not immediately obvious to me looking at this bullet.

Q. Okay. Well, with respect to hospital or other facility stays, in the fourth bullet, would it be appropriate, when evaluating a request for coverage, for the administrator to consider whether safe and adequate care can be provided in a less intensive care setting or in an outpatient setting?

A. It would be. And, I'm sorry, other facility stays would include residential care.

Q. And looking at the sixth criteria here, "The services or supplies are the most appropriate which can safely and most economically be provided to the patient," would it be appropriate for the plan administrator to also consider whether that criteria has been satisfied?

A. Yes.

Q. Mr. Dehlin, let's turn back to Exhibit 225, which is the Certificate of Coverage we were looking at earlier.

And we were looking at the definition of covered health Services under that plan. What is the next step you would take in order to determine what is covered by this plan with respect

to mental health services?

A. You would look at the definition of covered health services. You would look at the list of specific covered health services. Then you would look at the exclusions.

Q. Okay. Let's start with the definition of specific health services. If I can direct your attention to page 37, please, of Exhibit 225.

And this section is "Section 1: Covered Health Services." Is this the section that defines the specific services that are covered for different types of treatment?

A. It is.

Q. And can this section be changed through amendments to the plan?

A. Sometimes, yes?

Q. Let me direct your attention to page 101 of Exhibit 225.

And this is titled "Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Amendment."

Do you see that?

A. I do.

Q. What is the purpose of the Mental Health Parity and Addiction Equity Act of 2008 to the certificate of coverage?

A. So the purpose of this amendment as a whole was, when there was mental health parity legislation passed, we needed to modify our documents to make sure that we were in compliance. So this memo will include various changes to the plan to ensure

that compliance.

Q. In looking down near the bottom of page 101, do you see the bolded heading that starts:

"Mental health services, neurological disorders, autism spectrum disorder services, and substance use disorder services in the certificate Section 1: Covered Health Services are deleted and replaced by the following"?

Do you see that?

A. I do see it.

Q. Or "replaced with the following."

So does this amendment override the earlier description of covered health services with respect to mental health and substance use disorders?

A. Yes, it does.

Q. If you can turn to the next page, on page 102 there's a section called "Mental Health Services" that flows on to page 102.

What is the purpose of that section?

A. I'm sorry, which section are you asking about?

Q. We're continuing below that heading. There's a section that starts "Mental Health Services"?

A. Right.

Q. And flows on to page 102?

A. I'm sorry. So for the specific -- in the list of specific

covered services in the Certificate of Coverage, there was a mention of mental health services.

This part of the amendment effectively replaces that, and it specifies the types of mental health services that are covered under the plan.

Q. Does this plan cover outpatient mental health treatment?

A. It does.

Q. Does it cover mental health treatment in an intensive outpatient setting?

A. It does.

Q. Does it cover treatment at a residential treatment facility for mental health conditions?

A. It does.

Q. And I see that the word "Residential Treatment Facility" is in initial caps. What does that indicate?

A. So a common convention in these documents is that phrases or words that are capitalized, when you might not expect that, are specifically defined in the definition section.

Q. So let me direct your attention, briefly, to page 97 of Exhibit 225; at the bottom of page 97 specifically.

Is that where we see the definition of residential treatment facility?

A. Yes, it is.

Q. And it says:

"A facility which provides a program of effective

mental health services or substance use disorder services, treatment and which meets all of the following requirements."

Do you see that?

A. I do.

Q. Second requirement reads:

"It provides a program of treatment under the active participation and direction of a physician and approved by the Mental Health/Substance Use Disorder Designee."

Do you see that?

A. I do.

Q. Is the Mental Health/Substance Use Disorder Designee, that's UBH?

A. That's correct.

Q. Is it correct to say that this plan requires the active participation and direction of a physician, as that term is defined by the plan, for something to qualify as a residential treatment facility?

A. That's correct.

Q. And the second bullet reads:

"It has or maintains a written specific and detailed treatment program requiring full-time residence and full-time participation by the patient."

Do you see that?

A. I do.

Q. So would this plan cover treatment in a residential treatment facility where the patient was not required to stay there full-time?

A. It would not.

Q. How about a program where the patient was not required to participate full-time?

A. It would not cover that either.

Q. Let's go back to page 102, which is where we were before we went to look up the definition.

And is this description of the mental health services that are covered under this plan the same as the description of covered mental health services in all of the plans you reviewed for this case?

A. No.

Q. Let's look at Trial Exhibit 233, which should be the next tab in your binder.

Are you familiar with Trial Exhibit 233?

A. Yes.

Q. What is it?

A. This is a Certificate of Coverage for an employer group called Science Systems and Applications, effective in 2011.

Q. So, like Exhibit 225, is this also a fully insured Certificate of Coverage insured by United Healthcare?

A. That's correct.

Q. Is this one of the plans you reviewed for the plaintiffs

in this case?

A. Yes.

Q. If I can direct your attention to page 47, please, of Exhibit 233.

Paragraph 14 says: "Mental Health and Substance Abuse Services."

Do you see that?

A. I do.

Q. Is this the part of this plan that describes the mental health and substance abuse services that are covered under the plan that is marked Trial Exhibit 233?

A. Yes, it is.

Q. And looking under "Inpatient," which is the first section, it reads:

> "Mental health and substance abuse services received on an inpatient basis in a hospital or an alternative facility, including transitional care and residential crisis services."

Do you see that?

A. I do.

Q. Is that a description of the inpatient services that are covered for mental health and substance abuse services in this plan?

A. That's correct.

Q. And would you need to look up all those capitalized words

to understand what they mean here?

A. You would.

Q. The next paragraph in this reads: "The Mental Health/Substance Abuse Designee" -- is that, again, UBH?

A. Correct.

Q. -- "who will authorized the services will determine the appropriate setting for the treatment."

Do you see that?

A. I do.

Q. Is that another example of UBH's discretion to determine benefits under this plan?

MR. ABELSON: Objection. Leading.

THE COURT: Overruled.

THE WITNESS: That's correct.

BY MS. ROSS:

Q. And looking below that, at the Outpatient Section, is this a description of the outpatient mental health and substance abuse services covered by this plan?

A. Yes, it is.

Q. And if you look down through those bullets, the sixth one says:

"Short term individual family and group therapeutic services including intensive outpatient therapy."

Do you see that?

A. I do.

Q. Does this plan cover long-term therapy in outpatient or intensative outpatient setting?

A. No.

Q. Let's turn to Trial Exhibit 1539, please. I think it's, again, the next tab in your binder.

Are you familiar with Trial Exhibit 1539?

A. I am.

Q. What is it?

A. This is an SPD. So a plan document for Wells Fargo, is the employer, effective in 2011.

Q. Is this another of the plans that you reviewed for this case?

A. Yes.

Q. Is this a fully insured or a self-funded plan?

A. This is a self-funded plan.

Q. I direct your attention to page 53, 0053, of Exhibit 1539. There's a section that starts "Mental Health and Substance Abuse Plan Benefits."

Do you see that?

A. I do.

Q. What is the purpose of this section?

A. This is -- one second, please.

Right. This is detailing the benefits for mental health and substance abuse benefits. So what's covered under this plan in that specific context.

Q. If I can turn your attention to the top of the right-hand column. There's a heading that says "Residential Treatment for Children and Adolescents."

Do you see that?

A. I do.

Q. And can you read for us the bottom paragraph of that section, the one that starts "Admission."

A. Sure.

"Admission to a residential treatment center is not intended for use solely as a long-term solution or to maintain the stabilization acquired during treatment in a residential facility or program."

Q. So does that description describe the type of residential treatment that is not covered by this plan?

A. That's correct.

Q. And if we can turn back to Trial Exhibit 2014, which we had previously looked at. I think it's in your second binder.

And is this a plan we looked at a few minutes ago?

A. Yes.

Q. And it's one of the plans you reviewed with respect to the sample in this case?

A. Yes.

Q. Let me direct your attention to page 0168, of Exhibit 2014.

Are you there?

A. I am.

Q. And about halfway down the page there's a section that says "Inpatient facility based mental health or substance abuse treatment."

Do you see that?

A. I do.

Q. And the second paragraph begins "RTC." Do you see that?

A. I do.

Q. What does "RTC" refer to there?

A. RTC is an idiosyncratic acronym for residential treatment services. It's defined in the prior paragraph.

Q. And can you read for us the first three sentences of that paragraph, please, the one that starts "RTC."

A. (Reading)

"RTC is a psychiatric or substance abuse treatment program that provides 24 hour supervision, structure, and treatment. Residential treatment is a short term intervention to stabilize the presenting problem within a reasonable period of time. RTC is not intended to be for the purpose of providing respite for the family, protection from community influences, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for active treatment of a behavioral condition."

Q. So does this section describe the scope of coverage that's

available for residential treatment for mental health and substance abuse treatment under this plan?

A. It does.

Q. And in administering this plan, would it be appropriate for the plan administrator to consider whether the treatment falls within the description set forth here on page 168?

A. It would.

Q. Okay. Let's go back to Exhibit 225, which is the plan we've been working our way through.

So we've looked at the definition of Covered Health Services, and we've looked at the sections of the amendment that describe coverage for mental health treatment. Is that right?

A. That's correct.

Q. So what would be the next thing you would want to look at to understand the scope of coverage for mental health treatment under this plan?

A. You would want to look at the exclusions section.

Q. And if I can direct your attention to page 106, please, of Exhibit 225. This is also in the mental health parity amendment.

Does the mental health parity amendment of this plan also replace the exclusions and limitations section with respect to mental health and substance use disorder treatment?

A. It does.

Q. And starting on page 106, and continuing on to page 107, do you see the nine points that are listed there?

A. I do.

Q. What are those nine paragraphs?

A. So those are nine different specific exclusions that apply to mental health services under the plan.

Q. So if any one of those paragraphs applies, is coverage excluded or limited?

A. That's correct.

Q. And is that true even if the treatment would otherwise meet the definition of covered health services?

A. That's correct.

Q. And is that true even if the treatment would otherwise be consistent with generally accepted standards of care?

A. That's correct.

Q. Let me direct your attention to paragraph 9, which appears on Trial Exhibit 225, page 107.

Do you see that?

A. I do.

Q. And it starts:

"Services or supplies for the diagnosis or treatment of mental illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, or any of the following."

Do you see that?

A. I do.

Q. And, again, you've testified that the Mental Health/Substance Use Disorder Designee means UBH?

A. That's correct.

Q. So these are, if UBH, in its reasonable judgment, decides that any of the following apply, what does that mean?

A. It means that the service would be excluded under the plan.

Q. Is this another example of UBH's discretion to make coverage determinations under the plan?

A. It is.

Q. So the first bullet under paragraph 9 says:

"Not consistent with generally accepted standards of medical practice for the treatment of such conditions."

So is it correct that the plan does not provide coverage for mental health services that are not consistent with generally accepted standards of medical practice?

A. Yes.

Q. Is that the only exclusion that applies?

A. No. There are several others.

Q. And the second exclusion says:

"Not consistent with services backed by credible research, soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome and, therefore, considered experimental."

Mr. Dehlin, does UBH have the discretion to determine when this exclusion applies?

A. Yes.

Q. And would that be an administrative decision or would that be a clinical decision?

A. In this instance, it would be a clinical decision.

Q. And how about the criteria above that, we were just talking about, "not consistent with generally accepted standards of medical practice," would the determination about whether that exclusion applies be an administrative decision or would it be a clinical decision?

A. That requires clinical expertise, so that would also be a clinical decision.

Q. And looking at the last bullet, "Not clinically appropriate for the patient's mental illness or condition based on generally accepted standards of medical practice and benchmarks," would the decision about whether that criteria excludes coverage be a clinical determination or would it be an administrative determination?

A. That would also be a clinical decision.

Q. Let me direct your attention to the third bullet here. This would read -- this would be the exclusion for services or supplies for the diagnosis or treatment of mental illness that, in the reasonable judgment of UBH, are not consistent with UBH's Level of Care Guidelines or best practices as modified

from time to time.

Is that what that exclusion reads, substituting "UBH" for mental health substance use disorder designee as you've previously defined it?

A. That's correct.

Q. So what if services are consistent with generally accepted standards of medical practice but not with UBH's Level of Care Guidelines, is that covered by this plan?

A. It would not be. If any of these bullets apply in a specific instance, the service would be excluded.

Q. And does this exclusion give UBH permission to create and apply any guidelines it wants even if they're absurd?

A. No. Their guidelines have to be consistent with the details and the intent of the plan.

Q. And in -- in interpreting the details and intent of the plan, does UBH have discretion to do that?

A. They have discretion, yeah.

Q. So if I can direct your attention to page 108 briefly, just the next page. There's a section that starts "Substance Use Disorders."

Do you see that?

A. I do.

Q. What is this section?

A. Again, this is part of the amendments that is replacing the specific exclusions for substance use disorders that apply

in this plan.

Q. Okay. And paragraph 4 of the substance use disorder exclusions on page 108, are those the same exclusions we were just talking about in paragraph 9 of the mental health exclusions on page 107?

A. They are.

Q. Are the exclusions that we reviewed in Exhibit 225, with respect to mental health and substance use disorders, are those the same exclusions that apply to mental health and substance use disorder treatment under all the plans you reviewed in the case?

A. No.

Q. Let's look at Trial Exhibit 1548.

Do you recognize Trial Exhibit 1548?

A. I do.

Q. What is it?

A. This is a Certificate of Coverage for an employer called Sheridan Healthcare Center, that was effective starting April of 2011.

Q. So is this another fully insured plan that was insured by United Healthcare?

A. That's correct.

Q. And let's turn to look at the exclusions for mental health. If I can direct your attention to page 0030 of Trial Exhibit 1548.

Are these the exclusions that apply to mental health under this plan?

A. Yes, they are.

Q. Let me direct your attention specifically to paragraph 11. Do you see that?

A. I do.

Q. There are five criteria listed under this exclusion which reads:

"Services or supplies for the diagnosis or treatment of mental illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following."

Do you see that?

A. I do.

Q. Are these the same exclusions that we were just looking at with respect to Trial Exhibit 225?

A. No, not --

Q. Are some of them the same?

A. Yes.

Q. Which ones?

A. So the first one is not consistent with generally accepted standards of medical practice. The second one, I believe, may not be word for word but is very similar. After that I'd want to go back and double-check, but there are some that are very consistent.

Q. Okay. Let's look at the third one in particular. This is the exclusion for services or supplies that typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

Is that one of the exclusions that is the same as Trial Exhibit 225?

A. I think it's similar. I'd have to go back and check to be sure.

Q. Let's go back and look at page -- I think we were on page 107 or 106 -- 107.

If you can just compare paragraph 9 on page 107 with paragraph 11 on page -- I'm sorry, paragraph 9 on page 107 of Trial Exhibit 225 with paragraph 11 on page 30 of Trial Exhibit 1548.

My question was whether that third bullet appears in the exclusions listed in Trial Exhibit 225, the third bullet on page 30 of 1548?

A. Right. No, I don't see it.

Q. So let's turn back to 1548, at page 30.

Under this plan, would it be appropriate for UBH -- in addition to the considerations we talked about with the other criteria, would it be appropriate for UBH to consider in its reasonable judgment whether the requested mental health treatment results in outcomes demonstrably better than other

available treatment alternatives that are less intensive?

A. It would be appropriate, yes.

Q. Let's look at Exhibit 2023, please, which I think is in your second binder.

Are you there?

A. I am.

Q. Are you familiar with Exhibit 2023?

A. Yes.

Q. And what is it?

A. This is an SPD for an employer group, Met Life Healthcare Choices, effective January 2013.

Q. Is this one of the plans that you reviewed in this case?

A. Yes.

Q. If I can direct your attention specifically to page 0043 of Exhibit 2023. And it's -- has a heading that says "Behavioral Health Services Not Covered." Do you see that?

A. I do.

Q. What is the purpose of the list of bullets that starts on page 0043 and continues to page 0044?

A. In the context of behavioral health services, this is a list of exclusions that apply for this plan.

Q. And let's look at the very bottom of page 0043. Do you see that?

A. I do.

Q. What does the last exclusion on this page read?

A. It says "residential treatment services."

Q. So does this plan cover residential treatment services for behavioral health conditions?

A. It does not.

Q. And let's look at the second criteria, the second criteria here on page 43.

A. Okay.

Q. Does this plan also limit behavioral health coverage to the period necessary for short-term evaluation diagnosis, treatment, or crisis intervention?

A. It does.

Q. And would it require a clinical decision to determine whether the requested service met that -- fell within that exclusion?

A. It would.

Q. So would that be an administrative denial?

A. That would be a clinical denial.

Q. And let's look, also -- a little more than halfway down the page there's a bullet that starts "Treatment for mental illnesses that will not substantially improve."

Do you see that?

A. I do.

Q. It says:

"Treatment for mental illnesses that will not substantially improve beyond the current level of

functioning or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care as determined by United Behavioral Health."

Do you see that?

A. I do.

Q. So would UBH need to exercise its clinical discretion to determine whether that exclusion applies?

A. Yes.

Q. Would that be an administrative denial?

A. It would not. It'd be clinical.

Q. Okay. Let's go back to Exhibit 225.

THE COURT: Continue with 225 after our next break.

MS. ROSS: Sure. Thank you, Your Honor.

THE COURT: See you in ten minutes.

(Recess taken at 10:34 a.m.)

(Proceedings resumed at 10:54 a.m.)

THE COURT: Proceed.

BY MS. ROSS:

Q. Mr. Dehlin, right before we took a break we had been talking about exclusions and limitations that apply directly to behavioral health services; is that right?

A. Correct.

Q. Okay. So let's turn back to Exhibit 225, which is the COC for Granite Construction Group that we've been working through.

Are you there?

A. I am.

Q. Okay. Are there other exclusions or limitations in this plan that could apply to mental health or substance use disorder services?

A. Yes, there are.

Q. Can you identify those for us?

And it might help if I can direct your attention to page 0052, which is the beginning of the exclusions and limitations section.

A. Thank you.

So, going through the section, not all of the exclusion sections might apply to behavioral health, but many of them might.

The alternative treatment section, you know, could apply in some instances.

Subsection D is about drugs. Certainly, drugs are used in behavioral health treatment, and so this would need to be considered.

Certain behavioral health services could be experimental or investigational. So E could apply.

Obviously, H is specifically applicable to mental health.

And Section K, which is personal care, comfort, or convenience could come into play.

Section M talks about a number of different specific types

of procedures and treatment, and some of those could apply to behavioral health issues.

Subsection N talks about specific providers, and some providers' services are excluded, so that could come into play.

Obviously, Q is specifically about substance use disorders.

Section S, on travel, could apply to behavioral health services.

Section T, on types of care, could apply to mental health services and, specifically, the custodial care exclusion.

And then V is sort of a catchall of a variety of other types of exclusions, some of which might apply to behavioral health services.

Q. And would you need to look at whether any of those applied before you would know whether services were covered under the plan?

A. Yes, you would.

Q. So, Mr. Dehlin, we've been reviewing various sections of Exhibit 225.

Would you need to look at all of the sections that we've looked at to fully understand what's covered under that plan?

A. Yes, you would.

Q. Let's turn to what's been marked for identification as Exhibit 1653, which is in the third volume of your exhibits.

Mr. Dehlin, are you familiar with what's been marked as

Trial Exhibit 1653?

A. Yes, I am.

Q. What is it?

A. This is a document, it's a very long summary that looks at all of the different sample plans in the case, and excerpts, certain portions of those plans that could be critical to mental health substance abuse coverage or any issues relevant to this case.

Q. Does it include all of the sections of all of the plans?

A. It does not.

Q. Does it include the ones that you think would be important to determining the scope of coverage for substance use or mental health treatment?

A. Yes, it does.

MR. ABELSON: Objection, Your Honor. Again, he's not being offered for what he thinks is relevant to the issues.

THE COURT: Overruled. He's interpreting.

BY MS. ROSS:

Q. Mr. Dehlin, how did you decide what sections to include in the summary?

A. We, you know, looked at -- given some of the issues in terms of covering specific types of mental health and substance use, we looked at the sections that are relevant and very -- you know, closely follows the approach that I have talked to you about here today.

Talked about specific -- the definition of covered health services, specific coverages, including, you know, mental health and substance abuse, exclusions that apply to mental health and substance abuse services, definitions that are relevant to it. Those are sections that we've pulled into the summary document.

Q. And, to the best of your knowledge, is Exhibit 1653 an accurate reflection of those portions of the plans?

A. It is.

Q. Let's look at the first page and talk about how this is put together. There's a little box you see at the top there?

A. I do see it.

Q. Yeah. What information is contained within that -- that little box at the top?

A. So that box, as I understand it, includes the exhibit number in the context of all of the exhibits being used for this case. It includes a unique identifier, which, I think, often is the associated plaintiff name, although there are some instances where that's not the case.

It includes the plan name, and then it includes the plan date, the date for which the plan is effective, the first date for which the plan is effective.

Q. And then below that, if you look at the rest of the first page of Exhibit 1653, can you describe for the Court sort of how this chart is put together and what's reflected here?

A. Sure. So when you're looking at only excerpts from these plans, you often have to make sure you understand what section you're talking about. So we'll often include a section header, for example, the "Our Responsibilities."

But then the specific text that is excerpted there comes directly from the plan and it comes from the page number of the exhibit as shown in the column at right.

Q. And are these screenshots taken directly from the electronic versions of the plans?

A. That's my understanding, yes.

Q. And if we look at the entry here, this is Exhibit 225. So does this correspond to the plan that we've been looking at?

A. Yes, it does.

Q. And if we scroll down to the next page, we look, say, for example, on the section that -- there's a Section 9, "Defined Terms." So we can pull that up to page 90 of Exhibit 225.

At the bottom there's the definition of Covered Health Services that we were discussing that continues on to page 91. I think that's where we started with Exhibit 225 a while ago.

Does this chart then reflect that same language that appears in Exhibit 228?

A. Yes, it does.

Q. And if we looked back at Exhibit 1653 and we scroll down to page 6 of that exhibit.

So what is page 6 showing us?

A. Page 6 is a different plan.

So you can see at the top that it's the next plan in the summary; so the same things. It has the plan -- the exhibit number, a unique I.D., again typically the plaintiff's name, a description of the plan, and then the first effective date for that plan.

Q. And then below that, what do we see on page 6?

A. And below that, and for the rest of the pages, will be the specific excerpts taken from this plan and compiled into the summary.

Q. And then what's in the column on the right-hand side?

A. The column on the right-hand side, again, is for this exhibit. It's the number -- the page number of that exhibit that the excerpt was pulled from.

Q. And if we were to continue to scroll down through this exhibit, would there be an entry for each of the plans that you reviewed in connection with the plaintiffs and sample members in this case?

A. Yes.

Q. And to the best of your knowledge, is Exhibit 1653 an accurate summary of the portions of the plans that you've described as relevant to determining the scope of mental health and substance use disorder coverage?

A. Yes.

MS. ROSS: Your Honor, we move to admit Exhibit 1653

into evidence.

MR. ABELSON: No objection.

THE COURT: Admitted.

(Trial Exhibit 1653 received in evidence.)

BY MS. ROSS:

Q. Mr. Dehlin, if you can turn to what is previously admitted as Exhibit 892, which is the last tab of that binder, that third binder. If we can turn to page 2 after the cover page.

Mr. Dehlin, do you recognize Exhibit 892?

A. Yes.

Q. And did you review this document in preparing to testify here today?

A. No, I did not. I glanced at it briefly this morning, but I have not reviewed this document.

Q. Do you understand what it reflects?

A. I can tell you my understanding of what it reflects. And I briefly looked at one page at the back.

My understanding is this is a document from the plaintiffs, and it summarizes a variety of different sections from the plans, the sample plans in the case, including covered health services definition, the medically necessary or medical necessity definition, and then any specific exclusion language that applies to mental health and substance abuse.

Q. You mentioned you looked at a page at the back. If I can direct your attention to page 0021, is that the page that you

were referring to?

A. Yes, it is.

Q. And if you look at paragraph 2 of this page, it says:

"Chart includes the references to provisions within definitions of Covered Health Services, definitions of Medically Necessary, and exclusion sections specific to mental health and/or substance use disorder that contain one or more of the following phrases."

Do you see that?

A. I do.

Q. Then there's a number of phrases listed below that; right?

A. Correct.

Q. If you flip back to page 0002 of Exhibit 892.

Do you understand that this exhibit reflects where those particular phrases on page 21 appear in the plans?

A. That's my understanding.

Q. Would this chart give you all the information that you would need to know to determine what treatment is covered by the plans with respect to mental health or substance use disorder, in your opinion?

A. No.

Q. And you mentioned -- when we were talking about general exclusions that might apply, I believe you mentioned the exclusion for custodial care in Section T on page 0062 of Trial Exhibit 225. Is that right?

A. Correct.

Q. Is custodial care covered by this plan?

A. No.

Q. And is custodial care defined by the plan?

A. Yes, it is.

Q. Direct your attention to the definition section of the plan which starts on page 0090.

And on page 0091, do you see a definition for custodial care?

A. Yes, I do.

Q. And can you read that definition for us?

A. "Custodial care: Services that are any of the following:

First bullet:

"Nonhealth-related services such as assistance in activities of daily living. Examples include feeding, dressing, bathing, transferring, and ambulating.

Next bullet:

"Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function even if the specific services are considered to be skilled services, as opposed to improving that function to an extent that might allow for a more independent existence.

Next bullet:

"Services that do not require continued

administration by trained medical personnel in order to be delivered safely and effectively."

Q. So if treatment meets any of these criteria, would it be considered custodial under this plan?

A. That's correct.

Q. Is this the same definition of custodial care that appears in all of the plans for the plaintiffs and the sample members that you reviewed?

A. No.

Q. Did you review all of the plans for the plaintiffs and the sample members in the case to determine whether those exclude custodial care?

A. Yes.

Q. Do all of those plans exclude custodial care?

A. The vast majority do. There are a couple where there are pieces that are missing, but -- and it may not be a covered service, but the vast majority of them exclude custodial care.

Q. And did you review how those plans define custodial care?

A. We did. I did.

Q. If I can direct your attention to what's been marked for identification as Trial Exhibit 1654, please, which is again in Volume 3 of your binders.

Do you recognize Trial Exhibit 1654?

A. I do.

Q. What is it?

A. This is another summary document that -- where we went through all of the sample plans for this case and pulled out the definition of custodial care and then included it here.

And we also made sure that we recognized where in that plan there was an exclusion to custodial care.

So if you look at the document, the column on the left includes the verbatim text, the screenshot text, of any of the plans that are listed next to it.

And, again, we'll have the trial exhibit number related to that plan as well as the unique I.D. and the plan name for that plan; and then the specific page number from that plan where an exclusion to custodial care is mentioned; and then, finally, the page where we've pulled the screenshot of the definition of custodial care.

Q. And in the third entry down on this first page, I see an asterisk and a footnote in the definition citation.

What does that indicate?

A. Right. So many of the plans from the sample plans have exactly the same language for a custodial -- the custodial care definition. There are some instances where they were exceedingly minor. And, I'm sorry, when those plans have the exact same plan, we've tried to group them together.

Some of the plans have exceedingly minor and really nonsubstantive differences in the language. And in those cases we have still listed them with the others, but we've noted with

the asterisk that every single word and every single letter may not be identical.

Q. In your opinion, were those changes that are marked with an asterisk, do they change the meaning of the definition of custodial care in any way?

A. They do not.

Q. So if the meaning is different, did you group them separately?

A. Right. So if you go down, the first, the second, the third, the fourth, and the fifth pages all include plans that have, you know, that first definition of custodial care that has been listed.

Starting on the sixth page, there is a different definition of custodial care. So this is another definition that has many similar elements, but it's not the same. And so we've listed it separately along with all of the plans that have this definition.

Q. Okay. If the go to the seventh page, for example, the left-hand column is blank. What does that indicate?

A. Right. So you just have to go back up to the last listed definition of custodial care. In this instance there were too many plans to fit on one page, so these all have the same definition that shows up on page 6. We just didn't include it, to make sure that we knew where there was a break for a new definition.

Q. And does this exhibit continue on in that same formatting for each definition that you saw in the plans that you reviewed?

A. It does.

Q. And, to the best of your knowledge, does the summary accurately reflect the language defining custodial care in those plans?

A. Yes, it does.

MS. ROSS: Your Honor, we move to admit Exhibit 1654 into evidence.

MR. ABELSON: No objection.

THE COURT: It's admitted.

(Trial Exhibit 1654 received in evidence.)

BY MS. ROSS:

Q. Let's go back, Mr. Dehlin, to the first definition that shows up in your Trial Exhibit 1654 on page 0001.

Is that the most common definition of custodial care that you saw among the plans you reviewed?

A. It is.

Q. Let's put that definition of custodial care, if we can, side by side with Trial Exhibit 148, which, Mr. Dehlin, is in the binder you have up there that is for the guidelines in the case. Might have gotten set on the floor.

A. I have both.

Q. So Exhibit 148 is the Custodial Care & Inpatient

Residential Services Coverage Determination guideline that is dated March 2015.

Do you see that?

A. Yes, I do.

Q. Is this a document that you're familiar with?

A. I've glanced at one portion of it briefly.

Q. If you can, turn to page 0003 of Exhibit 148, particularly the second bullet point down under "Key Points."

A. Yes, I see that.

Q. Says: "Custodial care in a psychiatric inpatient or residential setting is any of the following." And there's three bullets?

A. I see it.

Q. Do you recognize that language that appears on Exhibit 148 at 003?

A. I do.

Q. Where does it come from?

A. That language is, I think, verbatim, but if not verbatim, incredibly close to the language from the definition of the most common definition of custodial care from Exhibit 1654.

Q. And let's keep Exhibit 1654 open on page 1. And if we can pull up next to that -- if you can turn to Trial Exhibit 195, which is the coverage determination guideline for custodial care and inpatient and residential services with a revision date of April 2016.

Do you see that?

A. I do.

Q. Again, if I can direct your attention to the second bullet point under Key Points on page 0003 of Exhibit 195?

A. I see it.

Q. "Custodial care in a psychiatric inpatient or residential setting is any of the following."

Do you recognize that language?

A. I do. Again, it's, I believe, identical, if not identical, virtually identical, to the most common definition of custodial care from the sample plans.

Q. And that's plan language within the plans?

A. Correct.

Q. Let's look at Trial Exhibit 221, still keeping one hand on 1654, on page 1, and turn to page -- to Trial Exhibit 221, please, which is the coverage determination guideline for custodial care inpatient and residential services with the effective date of March 2017. Do you see that?

A. I do.

Q. Again, if I can direct your attention to page 0003 of Trial Exhibit 221, the second paragraph begins, "Custodial care in a psychiatric inpatient or residential setting is any of the following."

Do you see that?

A. I do.

Q. Do you recognize that language?

A. Yes, I do.

Q. Where does it come from?

A. Again, virtually verbatim from the most common definition from the plan language of the sample plans from this case.

Q. Let's go back to Trial Exhibit 1654 now. And if you can turn to page 10 of Exhibit 1654. There we go.

What is shown here on page 10 in the first column, Mr. Dehlin?

A. This is a -- yet another definition of custodial care from a fairly large subset of sample plans from this case.

Q. And all of those plans are listed here in Exhibit 1654 that have that same definition?

A. Correct. It looks like this page and the two following pages have plans that have this definition.

Q. Okay. Let's keep that up. And if you could also turn in your guideline binder that you have there to Exhibit 108, which is the Coverage Determination Guidelines custodial care and inpatient and residential services with a revision date of February 2014.

Are you there?

A. I am.

Q. And let's look at the Key Points box again on page 0003. Do you see that? And particularly the first bullet point on there.

A. I see it.

MS. ROSS: Mike, let's move up to the first one.

BY MS. ROSS:

Q. And it says:

"Custodial care in a psychiatric inpatient or residential setting is the implementation of clinical or nonclinical services that do not seek to cure or which are provided during periods when the member's behavioral health condition is not changing or does not require trained clinical personnel to safely deliver services."

Do you see that?

A. I do.

Q. Mr. Dehlin, do you recognize that language that appears in the Custodial Care CDG for February 2014 on page 003 of Exhibit 108?

A. I do recognize it.

Q. Where does it come from?

A. It's not quite verbatim, but it's very similar to -- the line in Care is effectively the same meaning as, you know, part of this "custodial care" definition that we were looking at on page 10 of 1654.

Q. Let's keep 1654 up and let's turn now in your guideline binder to Exhibit 84, which is the Coverage Determination Guideline for Custodial Care and Inpatient and Residential Services dated January 2013.

A. (Witness examines document.)

Q. And, again, if we can direct your attention to page 003 of Exhibit 84 and the key points box to the first bullet.

A. I see it.

Q. Is that the same language that we just looked at in Exhibit 108?

A. It is.

Q. And where does that language come from?

A. Again, from the definition on page 10, which is, you know, one of the more common definitions of "custodial care" and "sample plans," page 10 of 1654.

Q. And if you can still keep 1654 up on page 10 and turn to Exhibit 47 in your guideline binder. This is the Coverage Determination Guideline for Custodial Care and Inpatient Services with a revision date of December 2011. Do you see that?

A. I do.

Q. Again, directing your attention to the key points box that appears on page 003 of Exhibit 47 and in particular to, in this case, the second bullet here. It reads (reading):

> "Custodial care and psychiatric inpatient or residential setting is the implementation of clinical or nonclinical services that do not seek to cure or which are provided during periods when the member's behavioral health condition is not changing or does not require

trained clinical personnel to safely deliver services."

Mr. Dehlin, do you know where that language comes from?

A. Again, that language is not verbatim and not structured the same way, but effectively has all of the same points as the "custodial care" definition on page 10 of Exhibit 1654.

THE COURT: So go down to the next line on Exhibit 47, page 3. There's another bullet point. Where does that language for the bullet point "'Custodial care' in this context is characterized by the following"? Do you know where that comes from?

Or let me put it differently, that doesn't come from the plan document; right?

THE WITNESS: I don't see it in this -- well, hang on. Let me read it one more time, please.

THE COURT: Sure.

THE WITNESS: (Witness examines document.) Some of it does appear in this definition. The daily living skills relates to the first bullet point --

THE COURT: Uh-huh.

THE WITNESS: -- but I agree that there are other portions of it that don't come from this specific definition of "custodial care."

THE COURT: Okay. Thank you.

BY MS. ROSS:

Q. Now, Mr. Dehlin, in administering the behavioral health

benefits under the plans that you reviewed for this case, is it appropriate for UBH to make coverage determinations based on the definitions of "custodial care" that appear in the plan documents?

A. Yes.

MS. ROSS: We have no further questions right now, Your Honor.

THE COURT: Cross.

CROSS-EXAMINATION

BY MR. ABELSON:

Q. Good morning, Mr. Dehlin. My name is Adam Abelson, counsel for the plaintiffs.

A. Good morning.

Q. Mr. Dehlin, you testified for a while this morning about various ways -- you were asked about other ways -- I'll start again.

You were asked various times about whether language would be appropriate to consider in connection with a benefit determination. Do you remember those questions?

A. I do.

Q. Did you look at any of the denial letters for any of the plaintiffs for the claim sample members in this case?

A. I know they are part of the documents that you guys have submitted, but I have not looked at them.

Q. So you have -- you don't know whether any of the

provisions you pointed to were in fact a basis or the basis of any of the denials for the plaintiffs of the claim sample?

A. I don't know the basis of the denials.

Q. Do you understand when a claims administrator like UBH issues a denial, it has to tell the member why the claim has been denied; right?

A. Correct.

Q. And that's for, among other reasons, so that the member knows why the claims administrator concluded that the coverage -- that the treatment for which coverage is sought is not covered by the plan that's being administered?

A. Say the question again, please.

Q. You understand that when a member has been denied coverage for a particular claim, they receive a letter; right?

A. Correct.

Q. And the letter has to say the basis on which the denial was based; right?

A. That's my understanding.

Q. And you don't know whether any of the provisions you pointed to in any of the plans were, in fact, one or any of the bases for the denials in this case?

A. I have not reviewed the denial letters, that's correct.

Q. And you are aware that all of the denials in this case did have as at least one basis the application of UBH's standard criteria Level of Care Guidelines or Coverage Determination

Guidelines; right?

A. I actually don't know that. I don't know the basis of the denials.

Q. You're not a psychiatrist; right?

A. That's correct.

Q. You're not a psychologist?

A. Correct.

Q. You have no clinical background whatsoever?

A. Correct.

Q. You're on the business side of UnitedHealth Group; right?

A. That's correct.

Q. Which is a sister company from UBH. It's not UBH? You don't work for UBH?

A. Also correct.

Q. And since 2010 you've mainly focused on product strategy you said?

A. Product issues of all types including product strategy, yes.

Q. And your goal in that and your responsibilities in that position is to keep your customers happy; right?

A. That's one of many responsibilities, correct.

Q. And when you've talked about customers, those are the plan sponsors; right?

A. Plan sponsors in a self-funded sense but, you know, employer customers in a fully insured sense. We also, you

know, view other folks as our customers. We're trying to keep our consumers happy. We're trying to keep providers happy. We're trying to keep all of those key partners happy.

Q. And your focus at United is on what you've called key accounts; right? Those are from 50 to 3,000 employees?

A. I didn't mention key accounts yet, but that's correct, that's the phrase we use for -- it's not always exactly 50 to 3,000 but that's approximate, yes. I mean, my focus has been beyond the key accounts.

Q. You testified for a while about Certificates of Coverage, COCs, and Summary Plan Descriptions, SPDs; right?

A. Correct.

Q. Those are the documents that set out the plan terms; right?

A. Correct.

Q. Sometimes you call the plan terms "the terms of coverage"?

A. That's correct.

Q. And the COCs and the SPDs set out what you consider to be your promises to the members?

A. Among other things, yes.

Q. Or your responsibilities to the members, I believe, as you put it; right?

A. Among other things, yes.

Q. So when a claims administrator like UBH is administering a plan, its responsibility is to apply the terms of the plan;

right?

A. Correct.

Q. So when you testified earlier today about the intent behind a plan, you are referring to the terms of the plan itself; right?

A. Correct.

Q. You pointed to a number of provisions in Exhibit 225, which is the plan for Granite Construction?

A. Correct.

Q. I take it you don't know what kind of treatment the person whose coverage is at issue -- who's covered by this plan was seeking in this case?

A. I don't know the specifics of the instance, no.

Q. So if you were told that this is a plan for a Mr. Alexander, one of the plaintiffs, whose denial related to intensive outpatient, then you would understand that pointing to an exclusion for residential treatment has nothing to do with the denial in this case; right?

A. If that were the case, I think that would be correct, but I don't know any of the details of the -- of that specific instance.

Q. You pointed to -- or strike that.

You were asked about a provision in one or two plans that use the term "cost effective," right, within the definition of covered health services, I believe it was?

A. That sounds correct, yes.

Q. Is there any reference to "cost effective" in all of the definitions of covered health services or medically necessary that you looked at?

A. So I looked at all of the definitions, but I was not looking for that phrase in particular. So I apologize, but I can't answer that comprehensively.

Q. And you have no idea whether any of the denials in this case were based on the treatment being not cost effective?

A. Right. Again, I don't know anything about the specific instance or denials in this case.

Q. Likewise, you pointed to a condition of residential treatment as short as opposed to long term. Do you remember those questions?

A. For that plan, yeah.

Q. Right. But, again, you don't know whether that denial was even for an RTC claim; right?

A. That's correct.

Q. Or if it was, whether the basis for the denial was that it was long-term RTC as opposed to short-term RTC?

A. That's correct.

Q. You're familiar with the Parity Act; right?

A. In general terms, yes.

Q. You testified you were involved with some of the -- scratch that.

You were involved in some of the amendments to Certificates of Coverage related to the Parity Act; right?

A. At that point -- I mean, I was aware of it. At that point of time my role, you know, didn't involve specifically making sure we were in compliance, but I'm aware of the Parity Act in general and aware of what changes we had to make in general.

Q. The Parity Act has provisions and regulations that govern what levels of care have to be provided. If the plan covers, for example, inpatient for medical/surgical, then you have to cover inpatient for mental health and substance use disorder; right?

A. Correct.

Q. And so if there are provisions in any plan that reports a limit coverage for mental health or substance use treatment that apply only to that side and not to medical/surgical, your understanding is that those would not be enforceable; right?

A. That's my general understanding, yes.

Q. And so if those provisions apply -- appear -- scratch -- strike that.

If there are provisions in these plans that you've cited that are on your Exhibit 1653 that if applied by UBH would violate the Parity Act, it would have nothing to do with whether the denials in this case are -- I'll withdraw that question.

Wait. So provisions that purport to limit a particular

level of care for mental health or substance use settings are not legally enforceable if applied to a denial; right?

MS. ROSS: Objection, Your Honor, to the extent it calls for a legal conclusion.

THE COURT: Sustained.

BY MR. ABELSON:

Q. But it is your understanding, is it not, that if a given plan covers skilled nursing facilities -- for example, for medical and surgical treatment -- that an exclusion for residential treatment for substance use or mental health treatment would not be enforceable in the context of that given plan?

MS. ROSS: Objection again, Your Honor, to the extent it calls for a legal conclusion.

THE COURT: Sustained. Let's move on.

BY MR. ABELSON:

Q. Now, you understand that the denials in this case were all ones where UBH was applying its standard criteria, the Level of Care Coverage Determination Guidelines; right?

A. I do not know that.

Q. Okay. Let's -- you were pointed to some of the exclusions for mental health and substance use disorder treatment; right?

A. Correct.

Q. Let's look at one of those. Exhibit 225. I believe it's page 107.

A. (Witness examines document.)

Q. This is the Number 9 on page 107 of Exhibit 225. Do you see that?

A. I see it.

Q. Do you see that the first bullet under Number 9 is "Not consistent with generally accepted standards of medical practice for the treatment of such conditions"; right?

A. Correct.

Q. You can leave that on the screen and pull up Exhibit 4, page 2.

This is in the binder of guidelines that you've got there.

A. (Witness examines document.)

Q. And you see at the top where it reads (reading):

"The Level of Care Guidelines is derived from generally accepted standards of practice for the treatment of behavioral health conditions"?

Do you see that?

A. I do.

Q. So do you have any reason to doubt that a denial as to which the Level of Care Guidelines were applied were denials that were based on this exclusion or one similar to it?

A. Ask the question again, please.

Q. So you see that this plan, 225 --

A. Yes.

Q. -- Exhibit 225, excludes services that are not consistent

with generally accepted standards of medical practice for the treatment of such conditions? And that is specifically in the context of mental health coverage; right?

A. Correct.

Q. You see the language in the Level of Care Guidelines that say that the Level of Care Guidelines are derived from generally accepted standards of practice; right?

A. Correct.

Q. So you've talked about a lot of other provisions in these plans. Do you have any reason to believe that when the Level of Care Guidelines are applied, they're applying any other provision of the plans other than that one?

A. I don't think I have any reason to believe or not believe. I don't know anything about the denials. There are a lot of different covered provisions and a lot of different exclusion provisions that I imagine might be involved.

Q. But you don't know whether they were the basis of any of the denials?

A. That's correct.

Q. Now, you testified about provisions in some of these plans that referred to clinical protocols or guidelines of the mental health substance use disorder designee; right?

A. Correct.

Q. And that's UBH?

A. That's correct.

Q. And you understand --

A. The vast majority of our plans. I'm sorry. In all of these plans, yes, that's correct.

Q. You believe that a provision like that appears in every plan that you looked at?

A. No. I'm sorry. I was referring to UBH as the designee for all of these plans.

Q. Okay. But you understand that not every plan in the claim sample has a reference like that; right?

A. Which reference are you talking about again?

Q. A reference -- let's look at the same -- the same document. Okay? Exhibit 225, page 107.

A. Okay.

Q. Do you see the third bullet point under Number 9?

A. I do.

Q. It says (reading):

> "Not consistent with the Mental Health Substance Use Disorder Designee's Level of Care Guidelines or best practices as modified from time to time."

Did I read that correctly?

A. You did.

Q. Is that one of the provisions that you were -- the type of provision you were pointing to as referring to UBH's Level of Care Guidelines?

A. That's correct.

Q. But there is not a provision like this in all of the plans of the plaintiffs in the claim sample; right?

A. So, again, I did go through all the documents and I looked at all of this. I was not looking for this specific language, so I can't answer that with certainty.

Q. Okay. Now, you also don't know whether Mr. Alexander's denial letter in this case --

THE COURT: Yes, he doesn't know anything about the denial letters. Keep going.

MR. ABELSON: Okay.

Q. If you are told that the denial letter did not reference any Level of Care Guideline but referenced a Coverage Determination Guideline, that wouldn't affect whether you think that provision would apply?

A. That's correct. There could be multiple types of care guidelines that would be -- that this specific phrase could refer to.

Q. You were asked about amendment provisions; right?

A. Correct.

Q. And UBH is a claims administrator; right?

A. Correct.

Q. UBH can't rewrite the plans?

A. That's correct.

Q. Its job is to administer the plans?

A. Correct.

Q. As written?

A. Correct.

Q. Every Certificate of Coverage has a plan year as I believe you testified; right?

A. Correct.

Q. And so if a UBH guideline were amended, for example, in the middle of a plan year, it couldn't amend the plans of the term; right?

A. Right. The plan is the plan for the year.

Q. Now, you testified about custodial care exclusions; right?

A. Correct.

Q. Now let's look at your Exhibit 1653.

A. (Witness examines document.)

Q. Let's look at page 37.

A. (Witness examines document.)

Q. You pointed to some of the definitions of "custodial care" that appear in some of the plans; right?

A. Correct.

Q. But there are others as well; right?

A. Correct.

Q. On page 37, for example, there's an exclusion that reads -- or a definition of the term that reads:

> "Services provided to a person for the primary purpose of meeting nonmedical personal needs, e.g., bathing, dressing, preparing meals, including special

diets, taking medication, assisting with mobility."

Did I read that correctly?

A. So I'm perhaps lost.

Q. I'm sorry.

A. Could you refer -- I think you referred me to 1653, a summary document of custodial care, versus document 1654.

Q. I meant 1654, page 37.

A. Okay.

Q. Now, that is another definition of "custodial care" that appears in at least one of the plans that you looked at; right?

A. It's applies in one of the plans that we looked at, yes.

Q. If you could leave that on the screen and pull up Exhibit 108, page 3.

It's your understanding that the Custodial Care Coverage Determination Guideline is what UBH uses if it is relying on a custodial care exclusion as the basis for a denial; right?

A. I'm sorry. Say it again.

Q. You understand that a Custodial Care Coverage Determination Guideline is what UBH relies on if it is denying a claim pursuant to a denial -- an exclusion of custodial care?

A. Okay. Yes.

Q. Now, does this -- just as an example, does this definition of "custodial care" in this plan say anything about a member not responding to treatment?

A. This definition of "custodial care" does not specify that.

Q. It says nothing about active treatment?

A. That's correct.

Q. It says nothing about improvement; right?

A. That's correct.

Q. And it says nothing about reduction or control of acute symptoms?

A. That's correct.

Q. Do any of the definitions of "custodial care" that you looked at include the phrase "reduction or control of acute symptoms"?

A. Again, I did go through all the definitions. I was not looking for that phrase specifically. I can't answer with certainty. It certainly did not appear frequently.

Q. You testified about exclusions for experimental treatment; right?

A. I did.

Q. And whether certain denials would have been clinical or administrative; right?

A. We also discussed that, yes.

Q. Do you have any knowledge of UBH's coding methodology?

A. I do not.

Q. You testified that for fully insured plans UBH bears risk if the costs are greater than anticipated; right?

A. I did not say that, no.

Q. I'm sorry.

A. UBH does not bear risk. UnitedHealthcare bears risk.

Q. You understand -- okay.

So let's go back to the relationship between UBH and UnitedHealthcare.

You understand that there are plans for which UBH bears risk; right?

A. So my understanding of -- so, first off, I can't testify at all to UBH's relationship with entities outside of UnitedHealth Group. I know absolutely nothing about that.

My understanding of the financial arrangements between UnitedHealthcare and UBH are very high level. My understanding is -- well, so I can't -- I mean, I can discuss that at a high level, but I do not know the details.

Q. You testified or were asked about Exhibit 892, which is a chart that was prepared by plaintiffs; right?

A. Correct.

Q. And I believe you explained it doesn't include all of the other exclusions; for example, those you included in your chart?

A. Correct.

Q. Does it provide enough information for you to determine whether one condition of coverage is that services have to be consistent with generally accepted standards of care?

A. Whether one set of what? Please repeat the question.

Q. So is it sufficient for you to determine whether, as at

least one condition of coverage, that the treatment for which coverage is sought meet one of the bolded phrases?

A. So you're asking if from this document I can conclude that as a condition of coverage, a service needs to meet generally accepted standards? Is that the question? I'm sorry. I'm not understanding.

Q. Correct.

A. Again, I haven't looked through this document. If it's a fair representation and if it always includes, you know, the -- you know, covered health services, then, yes, that would help understand that one coverage provision.

Q. Meaning that a condition of coverage is that the treatment meets that standard?

A. Generally accepted standards of care, although there are different phrases, correct.

MR. ABELSON: Nothing further.

THE COURT: Thank you.

Anything further?

MS. ROSS: No, Your Honor.

THE COURT: Okay. Thank you, sir.

THE WITNESS: Thank you.

(Witness excused.)

MS. ROMANO: Your Honor, UBH calls Dr. Andrew Martorana.

THE COURT: Okay.

(Pause in proceedings.)

MS. ROMANO: May I approach?

ANDREW MARTORANA,

called as a witness for the Defendant, having been duly sworn, testified as follows:

THE WITNESS: I do.

THE CLERK: Thank you.

Could you please state your full name for the record, and make sure you speak clearly into the microphone.

THE WITNESS: Yes. My name is Andrew Martorana. Last name is spelled M, as in Mary, A-R-T, as in Tom, O-R-A-N, as in Nancy, A.

THE CLERK: Thank you.

MS. ROMANO: Just one moment, Your Honor.

(Pause in proceedings.)

DIRECT EXAMINATION

BY MS. ROMANO:

Q. Good morning, Dr. Martorana.

A. Good morning.

Q. Who is your employer?

A. I'm employed by United Behavioral Health, UBH.

Q. What is your title at UBH?

A. My current title is Senior Behavioral Medical Director Northeast Region.

Q. Are you a medical doctor?

A. I am.

Q. Can you please describe your educational background?

A. After completing an undergraduate degree at Princeton, I went to the University of Illinois Medical School in Chicago, and then I had a four-year combined internship and psychiatric residency at the University of Illinois hospitals that followed that.

Q. When did you complete your residency?

A. 1985.

Q. Can you please describe your medical licensure and specialty?

A. I'm board certified in general adult psychiatry. I'm licensed in Illinois, Maryland, Virginia, New York, New Jersey, Connecticut, and Tennessee.

Q. Can you please provide a brief overview of your work in psychiatry since your residency?

A. I've been a psychiatrist for about 35 years or so. I initially came out of residency and affiliated with an established practitioner group. And once I was able to develop my own practice, then I was predominantly -- excuse me -- a solo practitioner. I treated patients in hospital as well as in the office. I did psychotherapy and medication management.

In addition, I had administrative positions, including I was medical director for Charter Hospital -- Charter Barclay Hospital in Chicago, and I was chief of service at Michael

Reese Hospital also in Chicago.

I did -- I was a residency training coordinator and medical student training coordinator at Ravenswood Hospital, which I was admitting at, and I did a fair amount of teaching of medical students and residents.

Q. Did you treat patients for both mental health and substance use issues in private practice?

A. I did.

Q. How long did you engage in a private practice that you just described?

A. 35 years. Until 2002.

Q. Was the practice for 35 years? You said your residency -- you completed your residency in?

A. I practiced from when I completed residency in 1985 until November of 2002.

Q. Is that about 17 years of practice?

A. I'm sorry. Yes. I've been a psychiatrist longer. I was -- yes, I was in practice for about 17 years.

Q. And approximately how many patients did you treat in your practice over those 17 years?

A. I never counted them, but it would be in the thousands.

Q. Did you treat adults?

A. I did.

Q. Did you treat adolescents?

A. I did.

Q. And how long have you been employed by UBH?

A. I've been employed by UBH since November 2002.

Q. Is that when you stopped practicing treating patients?

A. Yes.

Q. Can you describe generally what are your types of responsibilities you have as a senior behavioral medical director at UBH?

A. I have many responsibilities. I guess I should divide them into a couple buckets.

One is clinical supervision and the other would be quality improvement. So most everything falls into one of those two buckets.

Q. Can you describe the types of responsibilities you have that fall into clinical supervision?

A. Well, I have 10 direct reports, all board-certified psychiatrists, some are subspecialists. So I provide supervision, training, and such for them.

In addition, I have clinical responsibilities but not a reporting structure with the Care Advocacy staff, which are the other clinicians that operate within United Behavioral Health.

Q. As part of your oversight of the 10 medical directors and the care advocates, do you participate in any training activities?

A. I do.

Q. And can you briefly describe your responsibilities that

fall into quality improvement?

A. Well, within that bucket you can divide quality improvement into things that we do for individual members and things we do more broadly over a population.

So for individual members, one of the activities would be I co-chair the National Peer Review Committee and I sit on the Sentinel Event Committee. So these committees investigate incidents. So Sentinel Event investigates incidents that should never happen in treatment, like someone kills themselves in a hospital.

NPRC investigates clinical complaints from the members. So we'll review the chart. We may send out an audit team. And these are for our network providers. And if we find a deficiency, we'll ask for a corrective action plan. If that's not sufficient after multiple attempts, then the ultimate thing we can do is to remove them from the network.

Q. And you mentioned "network" a couple times. What is the network you're referring to?

A. Network is the group of providers, which would include facilities as well as individual providers across the country that we have a contractual arrangement with to provide services for our membership.

Q. You described your role on the National Peer Review Committee and the Sentinel Events Committee with respect to the quality improvement responsibilities. Are there other

responsibilities you have that fall into that bucket?

A. Yes. Well, in the broader population management-type activity there's a program called ACE, which is Achievements in Clinical Excellence, and this is a program where we meet with network facilities and go over data with them, some data that they may not have, that have to do with quality issues.

So, for instance, readmission data is not always accessible to a hospital because they may be readmitted elsewhere, so this information is valuable to them and it tells us something about the quality of care. And we work with the facility to identify, you know, what happened that the readmission rate went up. And it can be a variety of things, some that we can effect, some that they can effect, and, therefore, improve the quality of care for our people.

Q. Have you served on the committee called the Behavioral Policy and Analytics Committee or the BPAC Committee?

A. Yes, I have.

Q. And when did you serve on that committee?

A. Since about 2013, I believe, until it was disbanded in 2016.

Q. And do you serve on the Utilization Management Committee?

A. I do.

Q. Do you have a particular role on that committee?

A. I started out as a member, and UM Committee took over for BPAC; and for the last two meetings, I've been acting -- I have

been named the co-chair.

Q. Can you describe what the Utilization Management Committee does?

A. It reviews utilization management issues. So predominantly it reviews the policies and procedures having to do with utilization management, as well as the guidelines that are used for utilization management.

Q. And when did the Utilization Management Committee begin that responsibility?

A. It took over for the BPAC. So after BPAC disbanded, then UM Committee took over from there.

Q. Have you held any other positions in psychiatry outside of UBH since you've been employed by UBH in 2002?

A. Yes. I had a position as a physician surveyor for Ascellon Corporation, A-S-C-E-L-L-O-N. And this is a company that holds a contract with CMS to survey freestanding psychiatric hospitals for participation in the Medicare program. So we determine if they're qualifying. That would involve me as the physician surveyor with a team of nurses and social workers going into the hospital to make these determinations.

Q. And did that work involve the use of Medicare benefit guidelines?

A. Yes, it did.

Q. And did you have any role with a task force or committee

in Connecticut?

A. Yes. After the Sandy Hook tragedy, the so-called gun law was passed but a large chunk of that law had to do with mental health issues because that was the nature of the tragedy; and from there, there were a number of different commissions formed, and I was named by one of the state senators to the commission that dealt with mental health treatment for young adults.

Q. Was there any work product that was created out of that committee?

A. Yes. There was a report that came out of that committee with a variety of -- with analysis and recommendations, some of which are being implemented right now.

Q. Do you have any involvement in psychiatry professional societies?

A. Yes, I do.

Q. What organizations?

A. I am a life member of the American Psychiatric Association, and I am a member of the Illinois Psychiatric Society.

Q. Are you familiar with the American Board of Quality Assurance and Utilization Review Physicians?

A. Yes.

Q. What is that?

A. This is a not-for-profit group that has as its goal seeks

to improve the quality of care for people in treatment across the country. It's not specific for mental health, but it -- it upholds the science and pursuit of improving quality improvement and appropriate utilization management.

It was originally just for physicians. I was certified with them, and then they've since invited other healthcare professionals that aren't physicians that involve equality, improvement, and utilization management, and I was recently named a fellow.

Q. Now, in addition to your testimony today about your experience at UBH, have you also been identified as a nonretained expert to testify as well?

A. That's correct.

Q. And on what issue will you be providing that nonretained expert opinion today?

A. My opinions will have to do with the guidelines that UBH uses and whether they are in accordance with generally accepted standards of care.

Q. And what are the bases --

MS. REYNOLDS: Your Honor, if I may.

A number of the exhibits that were disclosed for this witness he disavowed having relied on for his opinion. We'd like to request a limiting instruction with respect to any opinion about whether UBH's guidelines are consistent with the sources that he disavowed relying on.

MS. ROMANO: Your Honor, we disagree with that presentation of the facts. Dr. Martorana was at one time also, in addition to being identified as a nonretained expert, he was identified as a rebuttal expert to speak specifically about the clinical decisions that were made for particular named plaintiffs as a rebuttal to one of the identified experts for plaintiffs.

He did prepare a report for that specific work. He won't be offering any opinion testimony in that regard because it dealt with individualized decisions.

In the course of his deposition, he was asked about the documents he relied on, and he had his rebuttal report with the documents he relied on for that opinion and he didn't include I think the issue here is some CMS benefit manuals and maybe an American Psychiatric Association document, but he was asked at his deposition about familiarity with some of these things. He did express familiarity with the APA guidelines and CMS in his deposition, so we don't believe there should be any limiting instruction here.

MS. REYNOLDS: Your Honor --

THE COURT: Yeah.

MS. REYNOLDS: -- the rebuttal report omitted all of the exhibits to which we have objected from the list. There are 25 of them. And, in fact, he was asked repeatedly whether he had reviewed any original sources to try to determine

whether or not UBH's guidelines were consistent with them, and repeatedly he said that he had not done it. And I can read from the transcript if that's helpful.

MS. ROMANO: Your Honor, he was asked if he had looked at those documents to prepare for his expert opinion in that deposition. He honestly answered he had not; but through the course of his work at UBH and as a psychiatrist, he is familiar with the APA guidelines and CMS benefit manuals, and some of his testimony disclosed that in his deposition.

THE COURT: Okay. So, I mean, did you not ask him about these things?

MS. REYNOLDS: Yes, he was asked, and he -- so, for example, on page 188 of his deposition, lines 5 through 22, in regards to this opinion -- and the opinion appears on page 186, which is the UBH's Level of Care Guidelines from 2011 to 2017 -- were created to be and are consistent with generally accepted standards of care in the behavioral health community. So the testimony is on page 188 (reading):

> **"QUESTION:** In regards to this opinion, other than your experience and your background with the guidelines, did you consult any other sources in order to arrive at this opinion?"
>
> Objection.
>
> **"ANSWER:** Consult any sources other than the understanding of how the UBH creates these, no.

"QUESTION: Okay. And with respect to the opinion that the guidelines are consistent with generally accepted standards of care in the behavioral health community, did you look at any sources to confirm that they are consistent with the generally accepted standards of care in the behavioral health community?

"ANSWER: I did not do any additional source verification."

And there are numerous examples like that.

THE COURT: So I'm going to deny the motion subject to a motion to strike. I think it's unlikely you're going to win your motion to strike, but I'll allow it if you want it.

MS. REYNOLDS: Thank you.

THE COURT: Okay. Go ahead.

MS. ROMANO: I think the question I had just asked Dr. Martorana was:

Q. What are the bases for the opinions -- for your opinions with respect to UBH's guidelines and generally accepted standards of care?

A. That would have to do with my years of being a psychiatrist, my training and background, my involvement with UBH in the creation of the guidelines, as well as using the guidelines every day in the course of my work.

Q. Dr. Martorana, what is UBH?

A. UBH is a managed behavioral healthcare organization.

Q. And what is managed behavioral healthcare?

A. Well, managed healthcare in general is a system by which you attempt to improve the member's experience in terms of accessing and receiving appropriate care. So a managed behavioral company deals with mental health and substance use issues and the member's experience in accessing and receiving care.

Q. Does managed healthcare include utilization management? Are you familiar with that term?

A. Yes. That's one of the tools that's used, yes.

Q. What is utilization management?

A. It's a set of procedures that seeks to ensure that the given member is receiving appropriate, safe, effective, and efficient treatment.

Q. What is appropriate treatment?

A. Appropriate treatment is one that is based in evidence and is known to improve the member's condition.

Q. What is effective treatment?

A. That would be about the same thing I would say.

Q. And what is efficient treatment?

A. Efficient treatment is treatment that takes the least amount of time to achieve the result so the member's suffering is limited.

Q. Can you describe the levels of care that are used for behavioral health treatment?

A. Yes. From a least restrictive or least intensive to most restrictive/most intensive, you start with outpatient treatment, which is typically office-based care. You go see your therapist once a week in the office for a therapy session.

Then the next step up in terms of intensity would be called intensive outpatient treatment, which involves 6 -- 6 or more hours up to 19 hours per week of programming for an adult and -- I'm sorry -- 9 to 19 hours for an adult and 6 to 19 hours for an adolescent. This would include individual as well as group treatment in the intensive outpatient setting.

Then the next level up is partial hospital, which now is 20 or more hours per week. You're still living at home so it's an outpatient program, but it's for people that require a higher level of intensity of service. Again, individual group-type therapies are involved.

Then you move into the 24-hour levels of care, so that would be residential and inpatient.

So inpatient is the most intensive, residential is also 24 hours but is less intensive in terms of the involvement of medical personnel.

Q. For partial hospitalization, is that a service that's typically provided in a hospital?

A. No. They're often affiliated with hospital systems but can be in a freestanding outpatient clinic as well.

Q. You've used the terms "least intensive," "most intensive,"

"least restrictive," "most restrictive." Is there a distinction between "intensive" and "restrictive" when you say that?

A. I tend to use them interchangeably, so "restrictive" doesn't necessarily mean restricting your freedom of movement but it does certainly in the case of a 24-hour treatment setting; but in terms of an intensity service in an outpatient setting, the restriction is more on your freedom in terms of your life. So if you're having to go 20 or more hours per week to a partial hospital, that would be considered more restrictive than seeing someone in an office once a week.

Q. And are you familiar with levels of care that are covered under Medicare?

A. Yes.

Q. Does Medicare cover all of the levels of care that you've just gone over?

A. No.

Q. Which ones does Medicare not cover?

A. Medicare does not cover residential services or intensive outpatient services.

Q. Does Medicare cover outpatient?

A. Yes.

Q. And does Medicare cover partial hospitalization?

A. Yes.

Q. And does Medicare cover inpatient hospitalization?

A. Yes.

Q. What levels of care covered under Medicare are closest to a residential level of care?

A. Well, as I laid out just now, the residential would fall between partial and intensive inpatient treatment. So it would be similar to inpatient because it's a 24-hour level of care, and it would be similar to partial in that there's 20 or more hours of programming per week. It would be reasonably typical of a residential program.

Q. Turning to a different topic now, Dr. Martorana, are you familiar with UBH's Level of Care Guidelines?

A. Yes.

Q. Have you used them in the course of your work?

A. I have.

Q. What is the purpose of UBH's Level of Care Guidelines?

A. The guidelines are a tool to assist our clinicians, care advocates, and peer reviewers to make coverage determinations.

Q. Have you had any role in the development of UBH's Level of Care Guidelines?

A. I have.

Q. What role?

A. Well, it starts in about June of the preceding year. They start asking for opinions from the internal clinical staff -- so care advocates as well as the doctors and the senior medical directors -- as to what we would like to see, what issues we've

noted using the guidelines for the previous year. And so we submit that to the work group that is drafting the revisions.

And then I have at times participated with the work group when invited to review some of the recommendations that were given or questions, and that would include not only the internal ones but also the opinions that we get from professional societies and as well as practitioners that use these guidelines.

And then, finally, in the BPAC and now the UM Committee, I'm involved in the approval of the drafts that are presented there.

Q. Are you familiar with Coverage Determination Guidelines used at UBH?

A. Yes.

Q. Have you used Coverage Determination Guidelines in your work?

A. I have.

Q. What is a Coverage Determination Guideline?

A. It's another document that serves as a tool to assist care advocates and peer reviewers to make coverage determination.

Q. Have you had any role in the development of Coverage Determination Guidelines?

A. Similarly as to the Level of Care Guidelines, although I don't believe I was on a work group for that in-between step.

Q. So when you say "similarly," are you referring to your

time on BPAC and Utilization Management Committee?

A. Yeah. So providing input at the front end and then the approval piece of the BPAC and UM.

Q. How does the content of a Coverage Determination Guideline compare to the content of a Level of Care Guideline?

A. Well, they're organized differently. They are according to conditions. So level of care is according to the situs of treatment; whereas, the CDGs are according to the condition. So there would be CDG for posttraumatic stress disorder, another for major depression, another for bipolar, et cetera.

Q. Do the Coverage Determination Guidelines include references to specific plan language?

A. Yes.

Q. Why is that?

A. The Coverage Determination Guideline is to assist you to apply the plan determination language. In addition, it applies only to specific UnitedHealthcare plans that had certain language in their coverage determination -- in their coverage documents. Sorry.

Q. Is there ever a case where Level of Care Guidelines and Coverage Determination Guidelines -- let me strike that and start over.

Is it UBH's practice to use both a Level of Care Guideline and a Coverage Determination Guideline for the same coverage decision?

A. No. The Level of Care Guidelines are used for plans that use medical necessity, and the CDGs are used for plans that don't have medical necessity in them.

Q. This case relates to 2011 all the way up to 2017. During that period, did all of the Coverage Determination Guidelines include all of the language from the Level of Care Guidelines?

A. No.

Q. I'd like to direct your attention to Exhibit 1186, if I can, and it should be in that binder in front of you.

A. (Witness examines document.)

MS. ROMANO: And for the record, another version of this document was admitted into evidence yesterday. This is a more final one because it has the signatures on the second page.

Q. Dr. Martorana, can you take a look at what's been marked as Exhibit 1186?

A. Yes.

Q. And tell me, do you recognize it?

A. Yes, I do.

Q. And what is it?

A. This is the utilization management program description for 2016 for United Behavioral Health.

MS. ROMANO: Move Exhibit 1186 into evidence.

MS. REYNOLDS: No objection.

THE COURT: It's admitted.

(Trial Exhibit 1186 received in evidence)

BY MS. ROMANO:

Q. Why does UBH have utilization management program description?

A. Well, this is required by our accreditation bodies, like the NCAA -- NCQA and URAC. They require a full program description that lays out all the attributes of how we do utilization management.

Q. Does this program description address the process for authorizing or not authorizing coverage for treatment?

A. Yes, it does.

Q. How does UBH become aware of a need for a coverage determination?

A. Well, there's typically a request. Most often we get these requests by telephone from the provider who calls into our queue, and one of the clinician care advocates talks to them and makes a determination. A member can also call and request authorization as well.

Q. And I'd like to direct your attention to page 8 of this exhibit, please.

A. (Witness examines document.) I'm there.

Q. And right toward the middle of the page there's a heading "Utilization Management Processes." Do you see that?

A. Yes.

Q. And does that address some of this process for making a

coverage determination?

A. It does.

Q. And you just testified about care advocates. What is a care advocate?

A. A care advocate is a clinician who has a master's degree or higher, functions in the front lines of our utilization management program interacting typically with the providers and the members.

Q. And what are UBH's practices with respect to a care advocate's job when a request for authorization comes in?

A. Well, typically it will come into the triage -- assessment and triage team. Those are care advocates. A care advocate will gather information, a lot of clinical information, from the provider and use that to compare against the appropriate guideline that they're requesting coverage for and then make a decision. They can make a decision to authorize or they would have to refer it to an M.D. for further consultation and discussion.

Q. And is there a list somewhere of the information collected by the doctor that then is provided to the care advocate as part of this process?

A. Yeah. That's in the best practices section of the Level of Care Guidelines.

Q. Does a care advocate have authority to authorize coverage for care?

A. Yes.

Q. And if the care advocate determines that he or she is not -- does not believe that the guidelines or coverage permits coverage for that particular treatment, what is UBH's process in that event?

A. So this is an unusual occurrence, first, because the care advocates authorize 90 percent or more of the requests. So in the rest of those cases if the information does not appear to meet guidelines for medical necessity and Level of Care Guidelines, for instance, the care advocate will consult with one of the medical directors, a psychiatrist.

And that can occur in a number of different areas. The care advocacy teams have what they call rounds, regular rounds. So they may meet four, sometimes five times a week in a group. They'll present a case with the information that's been received to the medical director, and then there will be a discussion. It could be about complexity of the case or it could be about whether it meets guidelines.

There are other venues where the care advocate has access to the M.D., including walking in the door and talking to them.

So there will be a discussion, and basically one of three things will happen. The doc will look at that and say, "This meets criteria," and then may give suggestions as to where the treatment should go down the road.

They may say, "There's not quite enough. There's holes in

this information. Go back and talk to them and ask them this, this, and this, and then see what they say. Then if it meets, fine. If there's still a question, you know, bring it back to me."

Or they look at it and say, "This information isn't lining up with the request that they have. So please schedule a peer-to-peer review."

Q. And if you turn the page to page 10 of this exhibit.

A. (Witness examines document.) Yes.

Q. There is a reference to peer-to-peer review determinations. Can you explain what a peer review is?

A. A peer review is the opportunity to -- for the attending provider to discuss directly on the telephone with a UBH peer reviewer, his peer, and in the process of this they gather as much clinical information as necessary to try and line it up with a level-of-care determination in their favor.

Q. Do you participate in peer reviews?

A. I do.

Q. If I can direct your attention to page 10 under peer-to-peer determinations, the second paragraph reads (reading):

"The purpose of a peer-to-peer discussion is to allow the treating physician practitioner the opportunity to share new or additional information about the case to assist the peer reviewer in making a determination."

Can you describe how you prepare for a peer review?

A. Okay. Well, I personally prepare by reviewing the available clinical information that's been collected by the care advocate, and that would be in our LINX clinical -- excuse me, LINX, L-I-N-X -- clinical chart. And so there would be all that information that's just collected. If the member has been admitted before that we managed, then I'd have that history as well.

If I had -- sorry.

Q. There's water next to you if you need it. Sorry to interrupt.

A. Thank you.

If there was a question in my mind as to what was in the LINX notes, I might reach out to the care advocate directly and ask some further questions. And so -- so with this, then I have an appointment scheduled to reach out to the provider.

Now, if I look at this information and it looks like it meets criteria, then I'll just go ahead and authorize it and tell the care advocate to pick up concurrent review. Otherwise, then I will proceed with the peer-to-peer review and have a live discussion with the attending.

Q. And can you describe how you conduct a peer review when you have that live discussion?

A. My personal style is to start with what we have. So I'll tell the doc, I'll say, "This is what I have," and I'll sort of

go over the highlights of the case.

And then I'll ask them, "You know, is this correct?" Because sometimes that's already just the basis of the decision is to do it, "Oh, well, you didn't hear about this, this, and this," and then we're done.

Otherwise, then, if he confirms that information, then I'll say, "Well, so, Doctor, we're wondering if this member can now transition to a less restrictive level of care given the improvements that were made and their current condition., for instance." And then they will give us information.

In the process of this, I'd like to get them to discuss the key reason. So part of our protocol for documenting is to list the key reason from the provider's point of view. "So, Doctor, you're saying that the key reason that this person continues to need treatment is that, you know, they're still dangerous, they've said so and that's why they still need to be in a 24-hour level of care?"

Then they'll say yes or no. Then we'll discuss whether it meets criteria, and in this case it would. And then if I authorize, I'll tell them so and give them an authorization time frame.

Q. And you just mentioned the word "criteria." Are you referring to Level of Care Guidelines or Coverage Determination Guidelines?

A. Yes. The applicable guideline, correct.

Q. When you conduct a peer review in your experience, are the providers familiar with UBH's guidelines?

A. Well, the network providers are generally familiar with it because they've signed a contract saying that they're going to abide by them. So they're reasonably knowledgeable if they have a large enough UBH practice.

Q. And what about the out-of-network providers?

A. Typically not. Some do that do see a lot of our members, but most of them don't -- don't have much familiarity with the guidelines.

Q. And after UBH doctors conduct the peer review, do they ever authorize treatment -- authorize coverage?

A. Yes.

Q. And what is the practice for notifying the provider or member of an authorization?

A. Well, I'll tell the provider when we're on the phone that this appears to meet our guidelines, and I'm going to go ahead and authorize it; and I'll tell them how long the authorization goes for, and I'll say that our care advocate will reach out with this information and schedule the next concurrent review prior to the expiration of the authorization.

Q. And if the decision is not to authorize treatment -- or, excuse me -- coverage or deny coverage, how is that conveyed?

A. Similarly I'm on the phone with the attending and I'll tell them that it doesn't meet our guidelines in my opinion,

and so the last covered date is thus and such, and you have appeals options and those will be communicated to you directly.

Q. Is the member notified of a noncoverage determination or a denial of coverage?

A. The written determination goes to both the provider and the member.

Q. Is an alternative level of care ever offered when the requested service is not covered?

A. In almost every case an alternative level of care that's available to the member is offered.

Q. And how is that conveyed?

A. Also at the same time during the discussion, if I'm saying that this doesn't meet the guideline and it does meet the guideline for this level of care, and we'd be happy to authorize that, sometimes they hear that and they say, "Okay. We'll take it." And then we move on and there's no denial issued. But if a denial is issued, there is the alternative level of care on the table.

Q. I'd like to direct your attention to page 16 of this program description.

A. Yes.

Q. At the bottom there is a reference to independent external appeals. What are those?

A. This is an appeal done by a clinician that's not part of United Behavioral Health. Typically for fully insured members,

this process is managed by the state whose laws govern the UM practices, and they have a process for setting up an independent external review. So it's a -- you know, these are often companies that have a panel of psychiatrists of various subspecialties, and they give them the case to make a determination on this would be binding on us.

Q. And does UBH view those external appeal decisions as binding?

A. Yes.

THE COURT: Find a good place for a break for lunch.

MS. ROMANO: Maybe four minutes or so, Your Honor --

THE COURT: Sure.

MS. ROMANO: -- and we'll be at a very logical place.

Q. In making these decisions you've described after a peer review, do UBH doctors use their clinical knowledge and judgment?

A. They must use their clinical knowledge and judgment. That's the primary reason they're there, and then they use that to -- within the framework of the guideline.

Q. And can doctors depart from the guidelines to authorize treatment?

A. If their clinical judgment takes them there, yes.

Q. Do they -- do the UBH doctors need to obtain authority from anyone else to depart from the guidelines?

A. No.

Q. Are the UBH doctors permitted to depart from the guidelines to deny coverage?

A. No.

Q. If I can direct your attention to page 39, please, of this exhibit.

A. (Witness examines document.) Yes.

Q. Toward the bottom under "Utilization Management Protocols," there's a heading "Affirmative Statement Regarding Incentives." Can you read that for me?

A. It says (reading):

"Optum distributes an affirmative statement to its clinical personnel, its members and practitioners and facilities in the Optum clinical network regarding its incentives to encourage appropriate utilization and to discourage underutilization. The statement consists of the following components:

"First, utilization management decision-making is based only on the appropriateness of care and service and the existence of benefit coverage; next, Optum does not specifically reward practitioners or other individuals for issuing noncoverage decisions; and, last, financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization."

Q. Is that policy you described consistent with UBH's practices?

A. Yes.
Q. Do the UBH doctors have any targets for the number or percentage of denials they should issue?
A. No.
Q. The UBH doctors who are making coverage decisions, is their compensation based in any way on the number of percentage of denials?
A. No.
Q. Are the performance evaluations of the doctors making these coverage decisions based in any way on the results of the coverage decisions, denials, or authorizations?
A. No.
Q. Do UBH's doctors consider other criteria or guidelines for patients with substance use problems in certain states?
A. Yes.
Q. What guidelines does UBH use for substance use coverage decisions in Illinois?
A. UBH uses ASAM guidelines.
Q. And for how long has it been doing that?
A. Since January of 2016.
Q. And how about with respect to Texas? What guidelines does UBH use for substance use decisions for plans governed by Texas law where the services take place in Texas?
A. Texas has its own guidelines that they've created and mandate for use. They're called TCADA, T-C-A-D-A, and we use

those guidelines for treatment in Texas for fully insured members.

Q. How long has that been the case?

A. When I started in 2002, they were using them then. So I don't know when it first started.

MS. ROMANO: This is a good time to break, Your Honor.

THE COURT: Okay. See you all in an hour. Thank you.

(Luncheon recess taken at 12:27 p.m.)

Tuesday, October 24, 2017 1:33 p.m.

P-R-O-C-E-E-D-I-N-G-S

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THE CLERK: We're back on the record in case number C 14-2346 Wit/Alexander versus United Healthcare.

MR. BUALAT: We have some sealing issues, that come up with the cross-examination of Dr. Martorana, that we'd like to raise with the Court.

THE COURT: Okay.

MR. BUALAT: We filed a motion yesterday evening; handed a courtesy copy to the Court. Two exhibits.

One reflects a request for legal advice to a UBH internal attorney. That's Exhibit 398. And the other document, 783, contains per-member-per-month rates and also information that could be used to calculate that from late 2014, that would apply to 2015.

THE COURT: Okay. Two questions: One, are you going

to use them, 783 and --

MS. REYNOLDS: The answer to the first question I don't know.

THE COURT: Okay. The second question, the redactions are fine. I have no problem sealing the exhibits. Are you going to use portions that are redacted?

MS. REYNOLDS: I can't say whether I am or not.

THE COURT: Start with legal advice. On the legal advice one, are you going to use portions of the redacted --

MR. BUALAT: That's 398.

MS. REYNOLDS: I mean, yeah, that's the substantive part of the email.

THE COURT: So we're going to do with these the way we did it. I think the per-member-per-month rates are critical to UBH. And so I'm not going to expose those even in testimony. So figure out a way, if you want to cross-examine that, to do if briefly. And at some point where you announce it, we'll clear the courtroom and go back on.

As to the others, just keep it brief. But I'm not going to seal the courtroom for the legal advice.

MR. BUALAT: Thank you, Your Honor.

MS. REYNOLDS: Thank you, Your Honor.

MS. ROMANO: We're proceeding with the examination of Dr. Martorana.

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DIRECT EXAMINATION

DIRECT EXAMINATION (resumed)

BY MS. ROMANO:

Q. Welcome back, Dr. Martorana.

A. Welcome.

Q. Do UBH's clinicians receive training on the use of Level of Care Guidelines and Coverage Determination Guidelines?

A. Yes, they do.

Q. Do you participate in trainings?

A. Yes, I do.

Q. Can you describe the training that is provided.

A. Well, during the new-hire orientation, there's a number of trainings that have to do with the guidelines. The new hires are introduced to the guidelines. They're shown where they exist how to maneuver through them; when they're applied.

And then there's a series of clinical-type trainings that help them walk through how to think about or use a thought process to think about a member and what they need and how to compare it against the guideline itself.

Q. And can you turn to Exhibit 1206, please.

Are you familiar with this exhibit?

A. Yes, I am.

Q. What is it?

A. This is the PowerPoint that goes along with the instructor-led training for new hires on Coverage Determination

Guidelines.

MS. ROMANO: Move for admission of Exhibit 1206.

MS. REYNOLDS: No objection.

THE COURT: It's admitted.

(Trial Exhibit 1206 received in evidence.)

BY MS. ROMANO:

Q. Dr. Martorana, can I direct your attention, please, to page 20 of this PowerPoint.

Is this an example of the clinical training you were just referring to?

A. Yes.

Q. And at the top it says "CDG Case Scenario #2." Do you see that?

A. Correct.

Q. Can you explain how a case scenario like this is used in a training?

A. So the trainees are presented with a typical case. They actually name the facility and note that the intensive outpatient program is asking for coverage. Then they describe the patient?

So she is 34. She has a divorce pending. There's various stressors associated with that and custody of her children. Her husband is harassing and abusing her. And she is diagnosed with PTSD, Posttraumatic Stress Disorder, migraines. And she's had a change in her normal functioning. She's showing signs of

isolating. Helpless, worried, crying all day, doesn't sleep, and not really taking care of herself the way she used to.

She has not voicing any suicidal or homicidal ideation. It is noted in the past she self-injured herself, but that hasn't been the current behave.

She is able to go to work but not functioning very well. She is able to care for her children. And she does have the support of a family member she is living with, having moved out.

It notes which medication she is taking, the dosage, and the treatment goals that the IOP is presenting at the time of admission.

Q. And is this, the type of information you've just read, the type of information that care advocates are trained to gather and evaluate to make a coverage decision?

A. Yes. This is typical.

Q. And if you can turn to page to pages 22 and 23, please, of this PowerPoint.

A. Yes.

Q. At the top there's a question that says: "What CDG are you reviewing for this scenario?" And under that it says: "PTSD."

How is this discussed in a training session?

A. As I mentioned earlier, the CDGs are organized differently. So they are by condition.

So the diagnosis needs to be described by the treating physician. And then the care advocate would turn to the PTSD CDG for guidance.

Q. And then there's a section that says:

"Does the treatment plan follow the required objectives, actions and timeframes outlined in the CDG?"

What's discussed in that portion?

A. This points out what's missing from the treatment plan that's being proposed. So it lists a number of important things that should be taken into account when approaching a member and how to appropriately and efficiently treat her condition.

Q. And are these the types of things that are discussed in trainings for all clinicians at UBH that make coverage decisions?

A. Yes.

Q. Are training materials for the UBH clinicians available to them after the completion of trainings?

A. Yes. The training department maintains an active web page with all the training materials and access to all the training for the trainees.

Q. Okay. Changing topics a little bit here, Dr. Martorana, are you familiar with generally accepted standards of care in the behavioral health community?

A. Yes.

Q. What does that mean?

A. Well, that means what is considered to be appropriate care within the treatment community across the country. These are based on a variety of sources of information, including studies, peer-reviewed studies in peer-reviewed journals; consensus guidelines from professional organizations; other guidelines such as ASAM, for instance. And the federal government, of course, has their own coverage determinations as well.

Q. You mentioned ASAM. Did you at one time write an article about ASAM?

A. I did.

Q. And in that article, did you propose that ASAM be used by providers as a patient placement criteria for their patients?

A. Yes. That article was directed at primary care. And we thought that was a fine way to help them organize their thinking.

Q. Do you like the ASAM criteria, Dr. Martorana?

A. I do.

Q. And did you, over the years, at different times support a proposal that UBH begin to use the ASAM criteria as its standard criteria for substance use coverage?

A. Yes.

Q. And why is that something that you supported?

A. For a variety of reasons. One, it's easier, sometimes, to

communicate, especially with the out out-of-network providers, assuming they understand what ASAM is about. So you would be speaking the same language.

It's certainly a well-documented guideline, which is why we rely on it, as well, for our guidelines.

It's readily available and publicly available as well.

They've also recently, now, developed a online tool, as well, which is a particularly helpful for helping people come to decisions.

Q. In supporting a change to ASAM for UBH, was it your belief that the UBH guidelines were not consistent with generally accepted standards of care?

A. No. They were consistent as well.

Q. And is it your opinion that they are still consistent with generally accepted standards of care?

A. Yes.

Q. UBH's guidelines?

A. Yes.

Q. And, as we mentioned before, this case covers years from 2011 until the 2017.

Do you have an opinion as to whether UBH's Level of Care Guidelines and Coverage Determination Guidelines have been consistent with generally accepted standards of care throughout that time period?

A. Yes, that's my opinion.

Q. I want to make sure it's clear here. So my question was: Do you have an opinion as to whether they are consistent with generally accepted standards of care over that eight years' range?

A. Excuse me. Yes, my opinion is that through the years in question the guidelines are consistent with the generally accepted standards of care in the country.

Q. All right. We're going to go ahead and start looking at the guidelines then. And they're going to be in a different binder for you, Dr. Martorana.

We're going to start with Exhibit 8, please.

A. Okay.

MS. ROMANO: Okay. Starting with Exhibit 8, Your Honor.

BY MS. ROMANO:

Q. Are these the Level of Care Guidelines that are currently in effect, 2017?

A. Yes.

Q. Okay. Let's start with the ones currently in effect. And if I can direct your attention to the section under "Introduction" on page 2 of Exhibit 8, please.

A. Yes.

Q. And I'm going to read the first part of that. It says:

"The Level of Care Guidelines is a set of objective and evidence-based behavioral health criteria used by

medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and well-being for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan California doing business as OptumHealth Behavioral Health Solutions of California Optum-CA."

Dr. Martorana, what does the language "support members' recovery, resiliency and well-being" mean?

A. Well, that refers to consumer-centric healthcare, where, we want our members to proceed in their treatment with regard to all aspects of their care.

So that would include, you know -- for instance, resiliency is the ability to withstand changes and stressors that perhaps they didn't have beforehand. Want to make sure that they're getting treatment that's evidence based as opposed to things that aren't evidence based which may or may not help them.

Q. Next paragraph reads:

"The Level of Care Guidelines is derived from generally accepted standards of behavioral practice. These standards include guidelines and consensus statements produced by professional speciality societies, as well as guidance from governmental sources such as CMS National Coverage Determinations (NCDs)and Local Coverage

Determinations (LCD)."

Are you familiar with NCD and LCD?

A. I am.

Q. Can you explain what they are?

A. Well, as mentioned, NCD is a national coverage determination, so it applies to every state in the country. The local coverage determinations are limited to specific regions or states; and so the treatment that's delivered in that state is subject to the local coverage determination.

Q. And are the NCDs and LCDs created to define Medicare coverage?

A. Yes.

Q. Are they UBH documents?

A. No, they're not.

Q. And the third paragraph states:

"The Level of Care Guidelines is also derived from input provided by clinical personnel providers, professional specialty societies, consumers and regulators."

Is that last paragraph I just read, is that consistent with your understanding as to how the -- part of the way the guidelines are created?

A. Yes.

Q. Looking under that, there's a section called "Guiding Principles." What are the guiding principles?

A. Well, this is a statement that they made to help people who are using the guidelines understand that -- how we approach member care in general, to ensure that people get the right care at the right time.

So they identify three pillars. So one is care advocacy, which has to do with us -- our clinicians, the care advocates -- intervening to assist members when they need help to decide what kind of care they need, to point them in the right direction, find them referrals.

And then on the other end, after they've had treatment, to make sure they connect with aftercare -- they got their medications paid for; they can make it to their sessions -- all these things that ensure that a member stays out of the hospital or stays in a less restrictive level of care.

The second one is the service system solutions. It has to do with the network. So we want to make sure that we maintain a network that's robust across the country; that has the full continuum of service whenever possible for our members so that they can access the proper care.

We also maintain the quality of the network through some of the means that I mentioned earlier.

And then, finally, information management technology has to do with how we use information. So there's -- we have a lot of data that we collect. And we use the data to help inform us as to, among other things, the quality of care in a given

situation.

So, as I mentioned before, with the ACE program, we have data on readmissions that we will use working with a hospital that may be having trouble finding aftercare, or something in their process that, you know, is contributing to a higher relapse rate.

So this shows us across populations what -- what the quality of care is in any given area.

Q. If I can direct your attention, now, to page 4. And looking toward the bottom of the page, fifth paragraph from the bottom, it says:

> "The Level of Care Guidelines are used flexibly, and are intended to augment - but not replace - sound clinical judgment. Use is informed by the unique aspects of the case, the member's benefit plan, services the provider can offer to meet the member's immediate needs and preferences, alternatives that exist in the service system to meet those needs, and member's broader recovery, resiliency, and well-being goals."

What does it mean that their -- "use is informed by the unique aspects of the case"?

A. Well, we think it's important as we -- as is present in our Best Practice Guidelines, to have a complete and thorough understanding of the totality of a member who's presenting themselves for treatment.

So not just the, you know, the fact that they, you know, tried to hurt themselves; that's why they're here. No. The question is: How did they come to this place at this time? What happened in their life with their environment, with their relationships? Did they stop taking medication? Is there co-morbidity impacting on this?

So the idea is to understand the member in their totality, as much as we can, as we make our clinical judgments. Which is how we would practice in our own practices as well.

Q. And looking at the next paragraph below that it reads:

"Exceptions may be made to the Level of Care Guidelines such as when there is a superceding contractual requirement or regulation or when a medical director authorizes a case-specific exception from using evidence-based treatment when the member's condition has not responded to treatment as anticipated.

"It is expected that exceptions be carefully thought out, documented, and approved by the responsible level of management. It is also expected that an effort will be made to work with the provider to identify an appropriate level of care and forms of treatment that are most likely to be effective."

Are medical directors the responsible level of management to have -- to be able to authorize an exception?

A. Yes. So, typically, the care advocate would approach the

M.D. and say, We have this situation. You know, they're asking for this and this and this. And, you know, this seems to not necessarily line up with the Level of Care Guidelines, but it appears to be the right thing to do.

And so then they make the decision at that point.

Q. And could a medical director make an exception on their own in a peer review?

A. Yes.

Q. Can you turn to page 6, please, of the 2017 Level of Care Guidelines.

A. Yes.

Q. This page is titled "Level of Care Guidelines Common Criteria and Clinical Best Practices for all Levels of Care."

And, Dr. Martorana, it's broken up into an Introduction and then Common Admission Criteria for all Levels of Care, Common Continued Service Criteria for all Levels of Care, Common Discharge Criteria for all Levels of Care, and then Common Clinical Best Practices for all Levels of Care.

Can you explain the common admission criteria, continued service, and discharge criteria? Why are they broken up into those categories?

A. Well, first of all, we have common criteria because we understand, in treating and approaching patients, there are certain things that cut across, principles that cut across all different levels of care.

So there's three decision points, typically, for us to make in a -- when reviewing a member's care. That's the front end, when they first come in to treatment and the request for admission to this level of care. And that needs to meet specific criteria.

And then the next question is: Do they need to continue in this level of care? And they -- that's what the continued service criteria are. They have their specific criteria.

And then at some point the member gets well enough to transition to a less restrictive level of care. And that would -- and the discharge criteria pertains to that.

Q. I would like to start with the Common Admission Criteria, and specifically with the top two bullets on page 7 --

A. Yes.

Q. -- where it reads:

"The member's current condition cannot be safely, efficiently, and effectively assessed and treated in a less intensive level of care;

"Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage; and

"The member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care.

"Assessment and/or treatment of the factors leading to admission require the intensity of services provided in

the proposed level of care."

What do these bullets that I just read mean?

A. Well, these are criteria that talk about how "less intensive" is thought through clinically.

So, basically, the -- our clinician and their clinician has to think through the process that understanding everything they know about the patient and what the treatment plan they're proposing the question is can -- can this safely, effectively, and efficiently occur in a less restrictive level of care, which is the preference, to have people least restrictive setting.

And then the flip side of that question is: Okay. In this level of care can you do all these things and take care of the member in a safe manner?

So we wouldn't want someone who is dangerous be in an outpatient setting necessarily. That would be one example where we would assess a higher level of care, for instance.

Q. Why is it a preference to be in the least restrictive setting?

A. It's a basic principle of psychiatric treatment that goes back quite a while and cuts across all -- all manner of treatment: that people should be free to live their lives as much as possible, as much as reasonable, as safe as you can when you're instituting psychiatric treatment.

Q. And are there external sources that support this

principle?

A. The basic principle is found in -- the UN puts out a directive. World Health Organization has their statement. And, of course, ASAM and the American Psychiatric Association have the same principle in their guidelines.

Q. Can I direct your attention to Exhibit 634. That's in the different binder in front of you.

A. 634, yes.

Q. And what is this?

A. This is the practice guideline for the Treatment of Patients with Substance Use Disorder, 2nd Edition, that the American Psychiatric Association publishes.

Q. Are you familiar with this document through your work?

A. I am.

MS. ROMANO: I move to admit, Your Honor.

MS. REYNOLDS: No objection.

THE COURT: It's admitted.

(Trial Exhibit 634 received in evidence.)

BY MS. ROMANO:

Q. If you can turn to page 22, please, Dr. Martorana.

A. Yes.

Q. There is a section called "Treatment Settings." And then a subsection heading called "Factors Affecting Choice of Treatment Setting"?

A. Yes.

Q. And can you read the first sentence there.

A. It says:

"Individuals should be treated in the least restrictive setting that is likely to prove safe and effective."

Q. Is that consistent with the principle of "least restrictive level of care" that you were just speaking about?

A. Yes, it is.

Q. Does that concept relate to just inpatient and residential treatment?

A. No. It's across the board.

I think I mentioned earlier that there's a distinction between a 24 hour level of care and an ambulatory level of care. But there's also the distinction between having to devote 20 hours of your life per week to treatment versus, you know, nine hours per week of treatment. And that would be considered a restriction, in my mind, as well.

Q. And can I direct your attention to Exhibit 639, please.

A. Yes.

Q. Are you familiar with this document?

A. I am.

Q. What is it?

A. This is the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 3rd Edition.

MS. ROMANO: Move to admit Exhibit 639.

MS. REYNOLDS: No objection.

THE COURT: Admitted.

(Trial Exhibit 639 received in evidence.)

BY MS. ROMANO:

Q. If I can direct your attention to page 16 of this document, please.

A. Yes.

Q. The very top there's a subheading that says "Establish the Appropriate Setting for Treatment."

A. Yes.

Q. Can you read that first sentence, please.

A. It says:

"The psychiatrist should determine the least restrictive setting for treatment that will be most likely not only to address the patient's safety, but also to promote improvement in the patient's condition."

Q. Is that provision consistent with the principles of "least restrictive level of care" that we were discussing?

A. Yes, it is.

Q. And do other APA guidelines include similar language?

A. Yes, many of them do. For instance, obsessive compulsive disorder guideline, bipolar guideline, others.

Q. All right. You can go ahead and put that binder to the side and return back to the common admission criteria for the

2017 guidelines.

Staying with the two bullets at the top of page 7, please, there's reference to "the member's current condition." What does the "member's current condition" mean?

A. The current condition is the set of symptoms that the member brings to the treatment, to the proposed treatment. So it has to do with, well, pretty much everything that is going on with them that has brought them to this point.

Q. Does that include chronic conditions?

A. Yes. Chronic conditions can impact the current symptoms as well.

Q. Now, what does it mean to evaluate whether the member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care?

A. Well, in terms of treatment planning, this is a basic part of treatment planning to identify the focus of treatment. So that would be, as we're talking about here, the current condition, the thing the member wants to have help with, and the thought process that goes into it knowing everything you know clinically about them, the disorder that they have, and the treatment options available.

Q. If I can refer you, now, to the next bullet point. So it's now the third bullet point on page 7?

A. Yes.

Q. Where it reads:

"Co-occurring behavioral health and medical conditions can be safely managed"?

A. Yes.

Q. What does that mean?

A. Well, many people present with treatment with additional conditions beside the one that they've identified as the focus of treatment.

And these are very important to deal with. They're called concurrent conditions. So someone could have an additional behavioral health diagnosis or a substance use disorder and, of course, medical conditions.

And the question, the thought process here is that a person with these co-occurring conditions, can they be safely managed in this level of care as well.

Q. What does "manage" mean in this sentence?

A. "Manage" means they're treated to the point where their symptoms don't interfere with the treatment of the primary diagnosis.

Q. And do co-occurring behavioral health and medical conditions include what's sometimes referred to as co-morbidities?

A. Yes.

Q. And does it include medical co-morbidities?

A. Yes.

Q. Can you give an example of what that would be?

A. Well, so someone who comes in with -- who's in alcoholic withdrawal. One of the co-morbidities that makes them tricky to treat them is if they have high blood pressure, for instance, that's also monitored to determine what level of withdrawal they're in. At the same time, then, you also know that their withdrawal will increase their blood pressure. So you have to make sure the blood pressure is monitored and controlled at the same time.

Q. And does the word here, "co-occurring behavioral health and medical conditions" include behavioral co-morbidities?

A. Yes.

Q. Can you give an example of that?

A. Well, someone could come in with a depressive disorder but have an underlying personality disorder, for instance, that will impact their treatment because the characteristics of the personality disorder may affect how you engage somebody.

So if a person has, for instance, a borderline personality disorder, you know that they may be highly reactive and very sensitive. So the approach may be different. You may include something called dialectical behavior treatment which is specific for borderline treatment in the context of treating their depression.

Q. When you're making coverage decisions, do you consider whether co-occurring conditions can be effectively addressed at the level of care?

A. Yes. That's how you manage something; you do that effectively.

Q. Do you consider whether co-occurring conditions warrant or could warrant a more intensive level of care to effectively treat the member?

A. Yes, that can happen. Definitely.

Q. Is there a provision in the guidelines that calls for consideration of that?

A. Yes. You're supposed to determine whether the person can be treated safely, effectively, efficiently in the level of care that they're requesting.

So part of the assessment is to determine whether the co-occurring problem is such that it requires a higher intensity of service.

THE COURT: So let's talk about this.

Pull up the whole screen.

So the first sentence talks about the member's current condition, the condition, the symptoms, et cetera, that bring them to you for treatment.

THE WITNESS: Yes.

THE COURT: And in that sentence you say "effectively treated." That's the test you want to have. "The member's current condition cannot be safely, efficiently, and effectively assessed or treated at a less intensive level of care and can be effectively, efficiently, and safely treated

and assessed at the proposed level of care."

Do you see that?

THE WITNESS: Yes.

THE COURT: Okay. And then when you get to "co-occurring" there's not a word about effectiveness. There's not a word about efficiency. There's only "safely."

How do you get out of that, that that means "effectiveness" when you don't use the words in that sentence but you use it in the two previous?

THE WITNESS: Right. The same words aren't used. But my understanding of medical care means that if you -- you're managing someone you're doing it appropriately. If you're not doing it appropriately, then you're not managing them.

THE COURT: Well, I'm not sure what "managing" means though. That's the question, what "managing" means.

In this context, you're telling the medical director or the care advocate that with respect to the current condition they have to find something that's effective; but with respect to the co-occurring behavioral health and medical conditions all they have to do is find something that can be safely managed.

You don't think they draw a distinction between those two?

THE WITNESS: I don't think so. Certainly --

THE COURT: Well, then why did you draft them with different words?

THE WITNESS: I did not actually pick these words.

THE COURT: Well, you approved these words. Why did you approve different words?

THE WITNESS: We didn't think it through in the way you're thinking it through now.

THE COURT: Ah. Okay. Thank you.

BY MS. ROMANO:

Q. Dr. Martorana, looking at the top two bullets, where it speaks of current conditions, I asked before if that would include chronic conditions.

Would it include co-occurring behavioral health conditions?

A. The current condition includes everything they bring to the table for treatment.

Q. Does that include co-occurring conditions?

A. Yes, it does.

THE COURT: Even though you describe co-occurring conditions in a separate bullet and use separate words? You meant that "current condition" to mean -- you expect people to understand it to mean including all of the possible things you're going to be treating?

THE WITNESS: Sometimes we put things in the Level of Care Guidelines to make sure people think it through in the clinical thought process. So don't forget, you know, if this person has co-occurring illnesses they need to be safely

treated in that setting.

THE COURT: Let me propose another way of thinking about this. This is the plaintiffs' way of thinking about this.

The plaintiffs' way of thinking about this is you put it in separate things because you meant different things. That is to say, you put co-occurring conditions in a particular standard of care different from the current conditions because you meant different things.

Why isn't that right?

THE WITNESS: I can understand they may think that. That's not how it's trained. So that wasn't our intention.

THE COURT: It's "not how it's trained."

THE WITNESS: Right.

THE COURT: When you say "trained" --

THE WITNESS: When we take new clinicians and current clinicians through the process of how to use these guidelines, we wouldn't be separating it out or parsing it in that way. It's more of a don't forget to consider these things; it's important.

THE COURT: Okay. Thank you.

BY MS. ROMANO:

Q. Dr. Martorana, I'm now going to direct your attention to the fourth bullet point on the top of page 7, where it says "Services are the following," and then there's four bullet

points underneath that.

Do you see where I am?

A. Yes.

Q. It says:

"Services are the following: Consistent with generally clinical practice; consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial outcome and are, therefore, not considered experimental; consistent with Optum's Best Practice Guidelines; and clinically appropriate for the member's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks."

What does this section mean that I just read?

A. Well, these are basically a big definition of what effective treatment is.

So effective treatment needs to have an evidence base behind it, have demonstrated that it does make people better. And Best Practice Guidelines, they're there to ensure that a full and complete assessment is made and appropriate diagnosis and treatment planning is made, which would be characteristics of effective treatment.

And then "clinically appropriate" means they match. There are some places that they just do the same thing for everyone no matter who walks in the door. And we want to make sure

they're individualized and known to be appropriate and effective.

Q. You just referred to the Best Practice Guidelines. Was that a reference to the third white bullet point in this provision?

A. Yes.

Q. And where are those Best Practice Guidelines located?

A. They're located within the Level of Care Guidelines.

Q. Can you direct the court to where you're referring to?

A. At the bottom of the page. It says "Common clinical best practices for all levels of care."

Q. How are those common clinical best practices for all levels of care used in making coverage determinations using these 2017 Level of Care Guidelines?

A. Well, first off, it's the standard we would hold a competent and qualified clinician to. So a thorough and complete assessment. All this information is collected and taken into consideration in terms of diagnosis and treatment. Appropriate diagnosis is made. And then there's a treatment plan that addresses the problems that are at hand, in an appropriate way and evidence based.

And so we would gather this information, hear what the clinician is saying. And if it makes sense and it's good clinical treatment, we would authorize it.

Q. Is that information in the clinical best practices for all

levels of care used in denying authorizations?

A. Not really. Unless we're seeing someone who's, you know, not competently evaluating the member; we may have a discussion with them about doing so. But it doesn't really end in a denial necessarily.

Q. Is that information collected and described in the common clinical best practices information that is collected and considered when evaluating whether a request for authorization should be authorized or denied?

A. Oh, I see. Yes, that would be a yes.

Q. And if I can turn your attention to the last bullet point, under the common admission criteria, where it says "There is a reasonable expectation that services will improve."

Do you see where I am.

A. Yes.

Q. (Reading)

"There is a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time. Improvement of the member's condition is indicated by the reduction or control of the signs and symptoms that necessitated treatment in a level of care. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement

must also be understood within the broader framework of the member's recovery, resiliency, and well-being."

This provision I just read refers to the "member's presenting problems." What does that refer to?

A. The presenting problems are the issues, complaints, and the condition that they present to treatment.

Q. What does it mean under this provision "for the presenting problems to improve"?

A. Well, this defines two ways that you can assess improvement. One is that by objective means that -- well, first of all, they have to have a treatment plan that you will expect to improve their condition.

Then when that's in place, then you would measure the improvement -- this is basic treatment planning -- in an objective manner. So it can be either reduction or control.

And then, also, you can consider improvement in someone by looking at and considering whether if you took this level of care away would they then deteriorate?

And then continue to require this level of care or even maybe a higher level of care.

Q. Does this provision include maintaining a condition or progress as part of improvement?

A. Well, that second part would incorporate maintenance because you're assessing whether the person will deteriorate if you withdraw treatment.

Q. And I asked you what "presenting problems" means. Does it include chronic problems?

A. Yes. It's the totality of the -- what the member is presenting when you consider treatment planning. So they may come in and say, you know, I'm depressed. But then if it's depression that's on top of, you know, co-morbidity or chronic depression or chronic medical issue, then all that will impact on how you treat this person effectively.

Q. This provision refers to improving the member's presenting problems within a reasonable period of time.

What does the "reasonable period of time" mean?

A. Well, that takes into account that the treatment is effective; but it also takes into account the member's -- the individual aspects of a member's condition as well as the -- what we understand about the condition itself.

So some conditions, we understand, will take a longer time than others. Like a person with obsessive compulsive disorder, for instance, the nature of the treatment, the repeated exposure-type treatment is lengthy. So that will take longer than someone else with a different condition.

Q. Is there a set period of time?

A. No.

Q. Is "reasonable period of time" defined anywhere in UBH's practices as a specific set period of time?

A. No. It's part of the clinical judgment that the reviewer

is applying.

Q. Looking at the second white bullet point in this improvement section, it says:

"Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends."

What does "improvement" in this context mean?

A. This refers to the major -- the black bullet point about having a reasonable expectation that the condition will improve.

Q. How does a UBH doctor weigh the effectiveness of treatment against the evidence that the member's condition will deteriorate if treatment is discontinued in the current level of care?

A. Well, that's, you know, one of those judgment -- clinical judgment decisions. And so we understand that a given treatment is effective. And we understand that the clinician is instituting the treatment aggressively.

And then we also know the member's prior condition in terms of their -- they may have a previous history of deteriorating when they're in a less structured setting, for instance.

Or a person could be in a residential setting, for instance, and they try them out on a pass to see how they do

without the structure of the residential program. And if they don't do well, then that would be a good indication that they continue to need residential treatment.

Q. What does it mean that "improvement must also be understood within the framework of the member's broader recovery goals"?

A. Again, that's another way to draw the attention to treating the member as a whole, not just as a symptom or two.

So, number one, it's always important to understand what the member wants from their treatment. Some clinicians still don't ask, and they just tell them what they want.

One of the conditions that you want to make sure you address is resiliency, which means the ability to withstand future stressors to, you know, maintain themselves outside of a restrictive level of care, for instance.

And well-being is not just mental but physical as well. And we understand that these are all interrelated and that a member needs to maintain both their health and their mental state all in the context of looking at treatment and what constitutes improvement.

Q. Do these 2017 common criteria require continuous improvement in order to remain in a level of care?

A. No.

Q. Does this section on improvement, that we're just gone over, mean that once presenting problems are improved, no care

is covered?

A. No.

Q. I'm going to direct your attention to the other binder in Exhibit 656, please, which has already been admitted into evidence.

A. Yes.

Q. Are you familiar with 656?

A. Yes.

Q. What is it?

A. This is the Medicare Benefit Policy Manual Chapter 6 - for Hospital Services Covered Under Part B.

Q. If you can turn to page 26, please, there's a section halfway down the page with a heading "Reasonable Expectation of Improvement."

Are you familiar with this language?

A. Yes.

Q. And is it your understanding that the improvement language we just went over in the common criteria at the Level of Care Guidelines is in some part based on the CMS language?

A. Yes.

Q. Reading from the second paragraph, under "Reasonable Expectation of Improvement," it reads -- and I'm in Exhibit 656, now, on page 26. It reads:

"It is not necessary that a course of therapy have as its goal restoration of the patient to the level of

functioning exhibited prior to the of the illness, although this may be appropriate for some patients.

"For many other psychiatric patients, particularly those with long-term chronic symptoms, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement.

"Improvement in this context is measured by comparing the effect of continuing treatment versus discontinuing it.

Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deterioration, relapse further, or require hospitalization this criterion is met."

The language I just read from the Medicare Manual refers to maintenance at a functional level. How does that relate to prevention of deterioration, if at all?

A. Well, by preventing deterioration, that's more or less the definition of maintenance, I would think.

Q. Also, what I just read from the CMS guidelines included reference to "long-term chronic conditions."

Do you see that?

A. Yes.

Q. And that sentence and language is not in the UBH guideline that we just looked at for 2017; is that correct?

A. Yes.

Q. Does that make UBH's guidelines more restrictive than the CMS guidelines on improvement?

A. I don't think so.

Q. Why is that?

A. Because we -- we've, I believe, used the parts of the -- we've defined "improvement" in a way that covers both acute -- treatment of acute symptoms and maintenance of conditions. So that would -- and, plus, we expect the clinician to take into account all the chronic aspects of a member's condition, if they exist, as part of designing the treatment plan.

So it should all be folded in there with -- with a competent clinician treating our member.

Q. I'd like to you keep both binders in front of you because we're going to do a little bit with both in a second.

But looking, now, back to the 2017 guidelines, Exhibit 8, and moving to the Common Continued Service Criteria for all Levels of Care.

A. Yes.

Q. At the top black bullet it reads:

"The admission criteria continued to be met and active treatment is being provided. For treatment to be considered active, services must be as follows:

"Supervised and evaluated by the admitting provider;

"Provided under an individualized treatment plan that

is focused on the factors leading to admission and makes use of clinical best practices;

"And reasonably expected to improve the member's presenting problems within a reasonable period of time."

If you know, where does this language come from, at least in part?

A. It's based on Medicare language as well.

Q. Can I direct your attention, now, to the other binder, Exhibit 655.

A. Okay.

Q. Exhibit 655 -- and this exhibit also has already been admitted into evidence.

Dr. Martorana, are you familiar with what this document is?

A. Yes.

Q. What is it?

A. This is the Medicare Benefit Policy Manual. Again, this is chapter 2 - Inpatient Psychiatric Hospital Services.

Q. Can I direct your attention to page 7, please.

A. Yes.

Q. And there's a heading called "Principles for Evaluating a Period of Active Treatment."

Do you see that?

A. Yes.

Q. And there's -- just above the bullet points it reads "For

services in an IPF." What is an IPF?

A. Inpatient psychiatric facility.

Q. (Reading)

"For services in an IPF designated as active treatment they must be provided under an individualized treatment or diagnostic plan; reasonably expected improve the patient's condition or for the purpose of diagnosis; and supervised and evaluated by a physician."

Is this the language you were referring to in the CMS guidelines?

A. Yes. This is where it comes from.

Q. There's a couple of differences I want to ask you about. The first one is going back to the 2017 guidelines now. If you can look at them.

In the common continued service criteria, under the definition of "active services," second white bullet, it reads:

"Provided under an individualized treatment plan that is focused on addressing the factors leading to admission."

So the additional language here is "that is focused on addressing the factors leading to admission"; is that right?

A. Yes.

Q. What does that additional language mean?

A. That calls out that one of the important parts of treatment planning should be to specifically address what

causes them to be in this level of care.

Q. And, in your view, is that consistent with the CMS guideline we just looked at?

A. Yes.

Q. Can the individualized treatment plan address factors -- under UBH's guidelines, can the individualized treatment plan address factors other than factors leading to the admission?

A. Yes, because it's individualized. And it becomes individualized when you've taken all that information that was noted in the common -- in the best practices and synthesize them into a case formulation, diagnosis, and a treatment plan that will improve their condition.

Q. Why should the plan be focused on addressing the factors leading to admission?

A. Well, that then comes back to the issue of the least restrictive setting.

So if the person can be treated safely, effectively, and efficiently in a less restrictive setting, then if you deal with the things that cause them to be in the more restrictive level of care, then you've -- should successfully be able to transition them to more freedom, a less restrictive setting.

Q. Now, in that circumstance, what if something else comes up in the course of their treatment that's new or different and wasn't a presenting condition or symptom at the time of admission? Is that considered when evaluating whether they should be stepped down to a lower level of care?

A. Absolutely. Had a case the other day where the member had been moved to a higher level of care because he was depressed and the outpatient treatment wasn't working so well. It was done by a psychologist. And so they put him on antidepressant, and there was no indication in his history, but it precipitated a manic event.

So the depressive symptoms have all obviously resolved, but now he has something brand-new that's brought on by the treatment or unmasked by the treatment. And, of course, if the person needed to be in that level of care, we would authorize that.

Q. And is there anything in the guidelines that would support consideration of new symptoms that -- conditions that cropped up in the course of treatment?

A. Well, it's part of the individualized treatment plan and looking at the member as a whole. Also, there's a feedback loop in here that, you know, if we're going to say that someone needs a less restrictive level of care, then they'd have to meet the guidelines all over again for that.

So, again, can they safely, effectively, and efficiently

be treated in that other level of care, and if the person's floridly manic, then the answer is no, they would need the higher level of care.

Q. Looking back at the active treatment definition, still in the Common Continued Service criteria, and comparing it to the CMS Guideline for Active Treatment, I want to call your attention to the third white bullet point where it says:

"Reasonably expected to improve the member's presenting problems within a reasonable period of time. The language 'within a reasonable period of time' is in the UBH guidelines and not in the CMS guideline."

Can you explain what is meant by "reasonable period of time" here?

A. Well, I think that's an additional piece to being effective. So you reasonably expect the condition to improve because the treatment plan is matched properly and the diagnosis is made appropriately.

But you could institute a treatment plan that's slower than others and so it would be less efficient. So we were asking that the care be efficient for the member's sake so they don't suffer as long.

Q. Now I want to turn your attention to the second black bullet point in the Common Continued Service criteria where it reads:

"The factors leading to admission have been

identified and are integrated into the treatment and discharge plans."

What does this mean?

A. Well, again, basic treatment planning requires that -- that part of the condition that's causing them to require the more intensive or more restrictive level of care is addressed, and there are specific problems identified and treatments that are identified, and expected outcome that's identified in measurable terms. That's what that refers to.

Q. Okay. Turning to the common discharge criteria under that, it reads: "The continued stay criteria are no longer met." And then there's a few examples underneath there. And the first example is:

"The factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care or no longer requires care."

What does that first example mean?

A. Again, there's a clinical decision to be made when someone -- the symptoms that someone came in with that required this level of care have been resolved. So then that was your goal or one of your goals?

And now that that's happened, can they be transitioned to a less restrictive level of care? So, as I was mentioning with the feedback loop, then all that comes into play. Can they

safely, efficiently, and effectively be treated in the less intensive level of care that may be available?

THE COURT: Why doesn't it say that? Why doesn't it use the words "efficiently" and "effectively"?

It says "safely transitioned."

THE WITNESS: Well, I think, as I mentioned, that part of the clinical decision is to think about the less restrictive level of care. And you have to answer those questions that mentioned -- for the admission criteria, is that can they safely, effectively, and efficiently be treated in this level of care that's now being proposed, the lower level of care.

THE COURT: This doesn't say that. This just says, "safely."

Why did you use that word instead of saying "safely, effectively, and efficiently" managed at a lower level -- being treated in a lower level of care?

THE WITNESS: I don't know for a fact why it's not there.

THE COURT: Okay.

BY MS. ROMANO:

Q. Staying with the common discharge criteria, the last white bullet point is another example for when a continued stay criteria are no longer met. And it reads:

"The member is unwilling or unable to participate in treatment, and involuntary treatment or guardianship is

not being pursued."

Why is this included as an example for when continued stay criteria are no longer met?

A. Well, as part of treatment planning, as you move along in the care, if the member is displaying an inability or -- to participate in treatment or unwilling to participate in treatment, then we would expect the treatment plan to change.

So they would bring into play any number of interventions depending on the individual aspects of the patient's care. So, you know, the motivational interventions bring in the family, what have you, to attempt to improve the member's condition by having them participate actively in the treatment.

Ultimately, if, for instance, you have someone who's very psychotic, out of touch with reality, needs antipsychotic medication but, because of their psychosis, is refusing it and so you're not giving them any medication, that if you haven't at least thought through the idea of taking them to court and having them given meds over objection, then you really haven't addressed the patient's condition or their suffering. And we would expect them to take those measures if that -- that came up.

Q. Turning to the common clinical best practices for all levels of care, which begin on the bottom of page 7.

You spoke about them a little bit already, Dr. Martorana. And I just want to ask you, are any of the items here listed on

page 8 items or circumstances that relate to information regarding co-morbid and co-occurring conditions?

A. The -- certainly, the bullet point that says "Co-Occurring Behavioral Health and Physical Conditions" would be one.

Q. Are there any others that you can identify?

A. Well, their medical history may involve co-occurring conditions. Developmental history may show the developmental delay that would be -- need to be taken into consideration as a co-morbidity.

Those would be the main ones dealing with co-morbidities.

Q. In this section, the Clinical Best Practices section, is this section directed only to what the treating provider should be doing and not what UBH's reviewing clinician should be considering?

A. This involves the coordination between us and the provider. This is the level of excellence and completeness we hold them to because they need to do this to make an appropriate diagnosis and an appropriate treatment plan, which they communicate to us.

And if they do all that and it makes clinical sense, then we would authorize that.

Q. If you can look at the third black bullet point on page 8 in the Clinical Best Practices section, it says:

"The provider and, whenever possible, the member use the findings of the initial evaluation and diagnosis to

develop a treatment plan. The treatment plan addresses the following:"

And then drawing your attention to the third white bullet point there, it says:

"The expected outcome for each problem to be addressed expressed in terms that a measurable, functional, time-framed and directly related to the factors leading to admission."

Why is this something to be included in the treatment plan?

A. Well, this is a basic aspect of psychiatric treatment planning. So if you see a treatment plan, especially for a complex patient, it may go on for pages.

So you'll have each problem identified, not necessarily diagnosis, but each problem identified. And then the treatment that's directed at that under it with specific expectations of the outcome and the time frame in which to expect that.

So someone comes in with suicidal thinking, then the treatment plan may say -- or the outcome expected would be that the patient is no longer voicing suicidal ideation by such and such date.

And if they don't do that, if they're still voicing suicidal ideation, then the expectation would be something else would be brought into play in the treatment plan to address it. So it's a constant, living, evolving document, and that's a

good and appropriate treatment.

Q. Now, turning your attention, sixth bullet down on page 8, it reads:

"Treatment focuses on addressing the factors precipitating admission to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care or the member no longer requires care."

Why is this included?

A. Because the principle of a least restrictive setting being of such importance that you want to make sure that the -- whatever factors that require them to be in this more intensive level of care are addressed and the goals related to treatment have to do with them improving to the point that they can be in a less restrictive level of care, which is preferable.

Q. Directing your attention to page 13 of the 2017 Guidelines. I'm sorry, stop on 10, please, for just a moment.

So on page 10 of the 2017 Level of Care Guidelines, there is a section titled "Level of Care Guidelines Mental Health Conditions."

Do the 2017 guidelines also have common criteria specific to mental health conditions?

A. Yes.

Q. And do they apply to all levels of care?

A. Yes.

Q. Are these the same common criteria we just went over in the general section?

A. They are.

Q. All right. Now, turning to page 13, please, there's a section titled "Guidelines: Outpatient."

Do you see that?

A. Yes.

Q. And if you can look at the paragraph starting "Outpatient," the second sentence, it reads:

> "The course of treatment in outpatient is focused on addressing the factors that precipitated admission, e.g. changes in the member's signs and symptoms, psychosocial and environmental factors or level of functioning to the point that the factors that precipitated admission no longer require treatment. Individual outpatient psychotherapy is generally provided in sessions lasting up to 45 minutes."

What are factors that precipitated admission? What does that mean?

A. Well, again, these are all the considerations that have led this member to this point in time seeking treatment.

So the symptoms that caused them distress, if there were precipitants for that; what their prior history has been; their co-morbidities; what's worked and what hasn't. All these things come into play as the factors necessitating or

precipitating admission.

Q. What are psychosocial and environmental factors?

A. Well, these are facets of a person that have to do with their relationships, where they live, their financial stability, if they're working, their educational status, marital status, things like that.

Q. Are factors that precipitated admission limited to acute symptoms?

A. No.

Q. Do factors that precipitate admission include chronic conditions, if they exist in a patient?

A. Yes.

Q. Why are individual outpatient psychotherapy sessions -- strike that. Let me restart that one.

Why is it that individual outpatient psychotherapy is generally provided in sessions lasting up to 45 minutes?

A. Well, that's the standard billing code that the AMA puts out for psychotherapy, so that would be -- a standard session would be 45 minutes for psychotherapy. Anything more than that would be an extended session.

Q. You said the standard code put out by who?

A. I'm sorry, American Medical Association. Misspoke.

Q. If I can turn your attention to page 14, please, of the 2017 guidelines.

About midway through, there's Intensive Outpatient Program

guidelines. Are these applicable to mental health?

A. Yes.

Q. Starting with the first paragraph, the last sentence, it reads:

> "The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life."

What does it mean to monitor and maintain stability?

A. Well, that means to structure your treatment and treatment settings so that you're regularly assessing the member's condition. And one of the goals would be to maintain stability, so whatever treatment interventions you have to institute to deal with this particular member's reasons for not being stable.

Q. And then looking at the next paragraph here in the Intensive Outpatient Program guidelines, it says:

> "The course of treatment in an intensive outpatient program is focused on addressing the factors that precipitated admission, e.g, changes in the member's signs and symptoms, psychosocial and environmental factors or a level of functioning to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care."

Is this generally the same language we saw for the

outpatient guidelines, just the level of care is different?

A. Yes.

Q. And is this language limited -- the factors that precipitated admission limited to just acute factors?

A. No.

Q. Do they include chronic conditions, if they exist, for the patient?

A. Yes.

Q. The next paragraph reads:

"An intensive outpatient program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders."

Does this intend to relate to co-occurring conditions?

A. Yes.

Q. How?

A. It's the expectation that someone accessing an intensive outpatient program or other levels of care, that if they have a co-occurring condition, that that be addressed too.

And, frequently, you'll see people with mental health disorders coming in with substance use co-morbidities and vice versa. And so it happens frequently enough that any mental health IOP should be able to assess and treat that as well.

Q. And looking back up to the top of this Intensive Outpatient Program section, it reads:

"A structured program that maintains hours of service for at least nine hours per week for adults and six hours per week for children/adolescents."

Why is it that there is a different minimum time for adults versus children?

A. Well, it's understood that for many children and adolescents the IOP is an after-school program, so by requiring too many hours, then you start interfering with their ability to do homework.

Also, it's known that, for especially younger children, that their attention span can be limited to the point that they don't really integrate too many hours of treatment all at once and so they -- the requirement is for a lower number of hours.

Q. Can I have you turn now to page 18 of these 2017 guidelines. Are these the residential treatment center guidelines for mental health?

A. Yes.

Q. Starting with the second paragraph here, it reads, "The course of treatment in a residential treatment center is focused on addressing the factors that precipitated admission, e.g. changes in the member's signs and symptoms, psychosocial and environmental factors or level of functioning to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care."

Again, does -- is this generally the same as the intensive

outpatient and outpatient guideline?

A. Yes.

Q. And I want to draw your attention now to the section underneath the residential treatment center admission criteria.

Do you see where I am?

A. Yes.

Q. And looking now at the third bullet point, it reads:

"The factors leading to admission cannot be safely, efficiently, or effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors."

And then it gives a couple of examples.

"Examples include the following: Acute impairment or behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

"Psychosocial and environmental problems that are likely to threaten the member's safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care."

What are acute changes in the signs and symptoms and/or psychosocial and environmental factors?

A. Well, acute changes are those that are immediate, generally short-lived, and have some impact as to why they need

to be in this level of care.

I think I mentioned what psychosocial environmental factors were earlier, but that would have to do with the person's living situation, for instance. And one of the points actually addresses -- the example addresses it directly.

So if you have a kid that's in some kind of abusive situation, then that's not going to be a good place for them to be to conduct treatment, so you put them in a residential setting, for instance.

But what was the other point?

Oh, psychosocial, as I mentioned before, the -- their employment, their education level, their relationships, whether they're married, they have kids; all of those things come into play when assessing a person's psychosocial condition.

Q. Now, the word "acute changes" -- or the term "acute changes" does not appear in the common criteria outpatient or IOP criteria for this year in 2017. Is that correct?

A. Yes.

Q. Why is it included here in the residential treatment criteria but not the others this year?

A. Uhm, well, we took it out of the other ones and we left it in here because we recognize that residential treatment is a 24-hour level of care for someone who requires a higher, more intensive level of care.

So we want to understand what happened, what changed

that -- what was the new change that happened that needs to be addressed that puts them into a 24-hour setting.

Q. And why did you take it out of the other levels of care and common criteria for 2017?

A. Well, this -- I mentioned before that in the process of doing -- of putting together the revisions to the Level of Care Guidelines, there's a workgroup that looks at the input from outside organizations.

And so the -- one of the national social work societies came in with comments about the word "acute" in the lower levels of care, outpatient and IOP.

And the feeling that that seemed to -- they used the word "tilt" the consideration to just acute care and wasn't really addressing the kind of patient that they often saw: someone that, you know, needed to come in once a week; otherwise, they would not do well; they would deteriorate and require, you know, probably more intensive level of care.

And they felt that that was a reasonable thing to do in terms of treating somebody's condition.

Q. Did you agree with the social workers' -- what was the association called? Do you know what it was called?

A. Clinical Social Workers -- CSWA, I think. Sorry, I don't recall specifically.

Q. I'll call them the social workers association if you understand what that means.

A. Yes. Thank you.

Q. Did you agree the social workers' association's interpretation that, by using the word "acute changes," it tilted the guideline toward acute care?

A. No, not really, because we did have all that language in there about defining improvement as maintaining someone in that level of care, because if you withdraw it, then they have a good chance of deteriorating, which pretty much described what they were saying.

So we didn't necessarily agree with their concern, but we registered their concern and felt that we could take it out. And it really didn't make that much difference one way or another in terms of, you know, what we were going to authorize and cover.

Q. Was that language, the "acute changes" language, was it used to disallow coverage for outpatient care for chronic conditions prior to 2017?

A. Not to my knowledge, no.

Q. I'm going to have you turn to -- back to the other exhibit, if you will, for just a couple of moments.

Exhibit 656, again, already admitted into evidence.

A. Yes.

Q. Directing your attention to page 29, please, of this document.

A. Yes.

Q. The second heading here, 70.3, says "Partial Hospitalization Services."

Does this -- this is the Medicare Benefit Policy Manual; is that right?

A. Yes.

Q. Chapter 6, does this section, beginning on page 29, apply to partial hospitalization services?

A. Yes, it does.

Q. And, again, partial hospitalization is a less intensive level of care than residential treatment?

A. Yes. It's a outpatient level of care versus a 24-hour level of care.

Q. Turning your attention to the section titled "Program Criteria," the second paragraph in that section, midway through the paragraph reads:

> "The Program reflects a high degree of structure and scheduling. According to current practice guidelines, the treatment goal should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission."

Are those concepts that also exist in the UBH guidelines as we've discussed?

A. Yes.

Q. In what way?

A. Well, it describes, you know, basic treatment planning in

terms of how to set goals, how they -- in terms of their being medically necessary. So if they're effective for the treatment, then you can measure the goals; they are not vague and unmeasurable. And that there's a time frame for determining whether you need to change your interventions because things have improved or haven't improved or things have gotten worse.

Q. Now, turning your attention to page 30, please. Are we still in the partial hospitalization section?

A. Yes.

Q. The top paragraph there, fifth line down, there's a sentence that reads:

> "The patients also require a comprehensive, structured multi-modal treatment requiring medical supervision and coordination provided under an individualized plan of care because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning, such dysfunction generally is of an acute nature."

What does it mean to say such dysfunction generally is of an acute nature?

A. Well, they're talking about conditions that are severe, and they often come up as, you know, exacerbations of a current condition or something relatively sudden. I mean, not

necessarily overnight. But it's -- acute means that it's of a recent onset, immediate onset.

Q. Now, turning to the next paragraph, please, in the middle of the next paragraph, it reads:

> "Where partial hospitalization is used to shorten an inpatient stay and transitions the patient to a less intense level of care, there must be evidence for the need for the acute, intense, structured combination of services provided by a PHP."

What is a PHP?

A. Partial hospital program.

Q. Is -- under Medicare, is partial hospitalization used to address acute, intense, structured combination of services?

A. Yes.

Q. Turning to page 31, please, does this section also apply to partial hospitalization coverage under Medicare?

A. Yes.

Q. At the section under Reasonable and Necessary Services, first paragraph, fourth line, there's a sentence that reads:

> "A particular individual covered service, described above as intervention, expected to maintain or improve the individual's condition and prevent relapse may also be included within the plan of care, but the overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms."

Is the concept of treating the serious presenting psychiatric symptoms also a concept that appears in UBH's guidelines?

A. Yes.

Q. In what way?

A. Well, we talk about the treatment planning having to address the reasons that a person requires this level and intensity of care.

Q. And now looking at the bottom paragraph, also on page 31, does this section still apply to partial hospitalization?

A. Yes.

Q. Third line down of that bottom paragraph reads:

> "Patients admitted to a PHP generally have an acute onset or decompensation of a covered Axis 1 mental disorder as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association or listed in Chapter 5 of the version of the International Classification of Diseases (ICD) applicable to the service date which severely interferes with multiple areas of daily life."

It refers to "an acute onset or decompensation." What is that?

A. Well, as we talked about before, acute means sudden. And, you know, by using the word "decompensation," they're talking about something pretty severe. So in this situation it's both

sudden and severe.

Q. And turning to page 33, if you will.

A. Yes.

Q. Are we still in the section on partial hospitalization?

A. Yes, we are.

Q. The very top paragraph reads:

"Reasonable and necessary denials based on 1862(a)(1)(A) are appealable and the limitation on liability provision does apply. The following examples represent reasonable and necessary denials for partial hospitalization services and coverages excluded under Section 1862(a)(1)(A) of the Social Security Act."

And then it reads:

"Patients who cannot or refuse to participate, due to their behavioral or cognitive status, with active treatment of their mental disorder except for a brief admission necessary for diagnostic purposes or who cannot tolerate the intensity of a PHP."

Is it your understanding that members who cannot or refuse to participate will not receive Medicare benefits for partial hospitalization under this manual guideline?

A. Yes.

Q. And then it reads:

"Also, with respect to reasonable and necessary denials, treatment of chronic conditions without acute

exacerbation of symptoms that place the individual at risk of relapse or hospitalization."

Is it also your understanding that individuals that are seeking treatment of chronic conditions without acute exacerbation of symptoms will not receive benefits for PHP under Medicare?

A. Yes.

Q. I'd like to direct your attention now to Exhibit 1507, please.

THE COURT: So let's take a short break before we do 1507. I'll see you in ten minutes.

(Recess taken at 3:00 p.m.)

(Proceedings resumed at 3:22 p.m.)

THE CLERK: Okay. We are back on the record in Case Number C 14-2346, which is Wit/Alexander versus UBH.

THE COURT: Go ahead.

MS. ROMANO: All right. Proceeding with the examination of Dr. Martorana.

Q. Dr. Martorana, before our break, I believe I asked you to turn to Exhibit 1507, please.

A. Yes.

Q. Are you familiar with this document?

A. Yes.

Q. What is it?

A. This is a Local Coverage Determination for a psychiatric

partial hospitalization program.

Q. Does this apply to Medicare coverage as you described before?

A. In certain states, yes.

MS. ROMANO: Move to admit Exhibit 1507 into evidence.

MS. REYNOLDS: No objection.

THE COURT: It's admitted.

(Trial Exhibit 1507 received in evidence)

BY MS. ROMANO:

Q. Dr. Martorana, I'd like to draw your attention to page 3 of this exhibit.

A. Yes.

Q. Excuse me. I have to get my glasses on for this one.

And, Dr. Martorana, looking to the second-to-last paragraph on page 3, please.

A. (Witness examines document.)

Q. Toward the bottom, four lines up there's a sentence that reads (reading):

"The degree of impairment will be severe enough to require a multidisciplinary intensive structured program but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need as certified by the treating physician for the intensive structured combination of services provided by the program that constitute active treatment that are

necessary to appropriately treat the member's presenting psychiatric condition."

This provision focuses on the patient's presenting psychiatric condition. Is that something that's also reflected in UBH's guidelines?

A. Yes.

Q. In what way?

A. It goes throughout our guidelines that we want to make sure that the attending provider has determined what so led this person to be in this level of care at this point in time and to make sure that's part of the treatment plan.

Q. And turning to page 17 of this LCD, please.

A. (Witness examines document.)

Q. And this is still a partial hospitalization LCD; is that right?

A. Yes. Yes.

Q. Okay. And looking at the section on the bottom, there is a heading that says "Admission Criteria Intensity of Service." Do you see where I am?

A. Yes.

Q. And it reads (reading):

"In general, patients should be treated in the least intensive and restrictive setting which meets the needs of their illness."

Is that a concept that's included in UBH's guidelines that

we've discussed already?

A. Yes, it is.

Q. And now I'd like you to turn to Exhibit 1502, please.

A. (Witness examines document.) Yes.

Q. Are you familiar with this document?

A. Yes.

Q. What is it?

A. This is a Local Coverage Determination for psychiatric inpatient hospitalization.

Q. So this one is for psychiatric inpatient hospitalization. Is that a higher level of care than residential treatment?

A. Yes, it is.

MS. ROMANO: I'd like to move Exhibit 1502 into evidence.

MS. REYNOLDS: No objection.

THE COURT: It's admitted.

(Trial Exhibit 1502 received in evidence)

BY MS. ROMANO:

Q. Dr. Martorana, if you could turn to page 9 of this exhibit, please.

A. (Witness examines document.)

Q. And there's a section titled "Limitations."

A. Yes.

Q. And the second paragraph under "Limitations" reads (reading):

"The following services do not represent reasonable and medically necessary inpatient psychiatric services and coverage is excluded under Title 18 of the Social Security Act, Section 1862(a)(1)(A)."

And then it reads (reading):

"First, services which are primarily social, recreational, and diversion activities or custodial or respite care; B, services attempting to maintain psychiatric wellness for the chronically mentally ill; C, treatment of chronic conditions without acute exacerbation."

Is that similar language we saw for PHP for Medicare?

A. Yes, it is.

Q. And now if I can turn your attention to Number 3. It states (reading):

"It is not reasonable and medically necessary to provide inpatient psychiatric hospital services to the following types of patients and coverage is excluded under Title 18 of the Social Security Act, Section 1862(a)(1)(A)."

And focusing specifically on item B, it reads (reading):

"Patient's whose clinical acuity requires less than 24 hours of supervised care per day."

Is it the case that patients whose clinical acuity does not require 24 hours a day of supervised care do not qualify

for coverage for inpatient treatment under Medicare?

A. That's correct.

Q. Okay. Let's go ahead and turn back to the 2017 guidelines, if we can.

A. (Witness examines document.)

Q. And still on the residential treatment center guidelines, at this time turning to the continued service criteria on page 18 and 19. Beginning on the bottom of page 18, it reads (reading):

"Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

"Nonhealth-related services such as assistance in activities of daily living. Examples include feeding, dressing, bathing, transferring, and ambulating.

"Health-related services provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function even if the specific services are considered to be skilled services as opposed to improving that function to an extent that might allow for a more independent existence.

"And services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively."

Do you know where that language, the three white bullet

points I just read, comes from?

A. Well, it's in the member's coverage documents.

Q. Turning to the Level of Care Guidelines for substance-related disorders on page 23 of Exhibit 8.

A. (Witness examines document.) Yes.

Q. Do the 2017 guidelines also have common criteria specific to substance use disorders that apply to all levels of care?

A. They do.

Q. Are these the same common criteria we went over at the beginning of our discussion of 2017 guidelines?

A. Yes.

Q. If I can direct your attention to page 26, please, of the substance use guidelines.

A. (Witness examines document.)

Q. This is a section on outpatient; is that right?

A. Yes.

Q. And if you can look at the first paragraph on outpatient, second sentence, it reads (reading):

"The course of treatment in outpatient is focused on addressing the factors that precipitated admission, e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or a level of functioning to the point that the factors that precipitated admission no longer require treatment."

Is this the same language that we saw in the mental health

outpatient section?

A. Yes.

Q. Is this section limited to acute changes?

A. No.

Q. Does it include consideration of chronic conditions?

A. Yes.

Q. And, again, it's limited to 45-minute sessions. Is that for the same reason you discussed before on mental health guidelines?

A. Yes.

Q. And then at the bottom of the page 26, it reads (reading):

"Coverage for extended outpatient sessions lasting up to 60 minutes may be indicated in the following nonroutine circumstances..."

And there's a series of bullets under there, one of which reads (reading):

"Periodic involvement of children, adolescent, or geriatric member's family in psychotherapy sessions when such involvement is essential to the member's progress, e.g., when psychoeducation or parent management skills are provided."

Why is this example that I just read a nonroutine circumstance?

A. Well, this would be an add-on to a regular session. You wouldn't necessarily normally have other people in the session

but when you do and it's important and essential to the treatment, then it makes sense that it takes a longer amount of time.

Q. And turning now to page 32 of the substance use guidelines for 2017.

A. (Witness examines document.) I'm sorry. What page?

Q. Page 32, please.

A. (Witness examines document.)

Q. The third paragraph reads (reading):

"The course of treatment in an intensive outpatient program is focused on addressing the factors that precipitated admission -- e.g., changes in the member's signs and symptoms, psychosocial and environmental factors or level of functioning -- to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care."

Again, is this limited to acute changes?

A. No, it's not.

Q. Does it include consideration of chronic conditions?

A. Yes, it does.

Q. And looking at the next sentence, it reads (reading):

"An intensive outpatient program can be used to treat substance-related disorders or can specialize in the treatment of co-occurring mental health and substance-related disorders."

Does this provision take into account comorbid conditions?

A. Yes.

Q. In what way?

A. Well, this is specifically referring to people entering substance use treatment, and that the expectation is the program should be able to handle any comorbid -- co-occurring mental health issues.

Q. And looking to the top of the section on intensive outpatient programs, there is again a distinction between the hours requirements per week for services for adolescents versus adults; is that right?

A. Yes.

Q. And why is that?

A. As I discussed before, there's an acknowledgment that a children's and adolescent's program are typically after school so more hours may tend to interfere with their homework time; and then it's also understood that for -- especially for children that the level of attention that they can bring may -- requires a limitation of hours in some circumstances.

Q. If I can direct your attention now to page 35 of the 2017 guidelines.

A. (Witness examines document.)

Q. Are these the -- toward the bottom half of the page, are these the substance use guidelines rehabilitation and residential?

A. I'm sorry. We're on page 35?

Q. 35.

A. Oh, yes. There they are. Okay.

Q. Do the plans UBH administers ever cover sober living homes?

A. Some plans require coverage, yes.

Q. Do they ever cover halfway houses?

A. If the plan says so, yes, we would cover it.

Q. Does UBH use these residential treatment guidelines to evaluate coverage for sober living homes or halfway houses?

A. No. There's a special guideline for sober living arrangements.

Q. Can I direct your attention to page 52, please, of the Level of Care Guidelines.

A. Yes.

Q. Still Exhibit 8. What is the -- what are the guidelines that are on page 52?

A. These are for sober living arrangements, which they -- they're also called, as they point out, drug-free housing, halfway house.

Q. Are these the guidelines that would apply if UBH was evaluating coverage for sober living homes or halfway houses?

A. Yes.

Q. Okay. If you can turn back to page 35, please --

A. Okay.

Q. -- under the guidelines rehabilitation residential bar and the second paragraph, it reads (reading):

"The course of treatment in residential rehabilitation is focused on addressing the factors that precipitated admission, e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or a level of functioning to the point that rehabilitation can be safely, efficiently, and effectively continued in a less intensive level of care."

Is this the same language we saw in the mental health guidelines?

A. Yes.

Q. And now looking at the bottom of the page, there is a section that starts "The factors leading to admission." Do you see where I am?

A. Yes.

Q. It's three bullet points up. (reading)

"The factors leading to admission and/or the member's history of" -- excuse me -- "history of response to treatment suggests that there is imminent or current risk of relapse, which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include a co-occurring mental health condition is stabilizing but the remaining signs and symptoms are likely to undermine treatment in a less intensive level of

care" -- excuse me -- "in a less intensive setting; and the member is in immediate or imminent danger of relapse and the history of treatment suggests that the structure and support provided in this level of care is needed to control the recurrence."

Does the section that I just read account for co-occurring conditions?

A. Yes, it does.

Q. In what way?

A. It calls out co-occurring mental health conditions and monitoring their progress as well.

Q. And then looking at the last bullet point that I just read, there is a reference to immediate or imminent danger of relapse, and what does that mean?

A. Imminent danger of relapse typically refers to time frame of days to weeks.

Q. And why is it that UBH is looking for an imminent -- excuse me -- immediate or imminent danger of relapse in evaluating whether residential is the appropriate level of care under these guidelines?

A. Well, understanding that substance use disorders are -- relapses are characteristic of substance use disorders for many individuals, that you would need to define the reason for the immediacy of treatment depending on how acute or immediate the risk of relapse is. Because, you know, if they might relapse

in 6 months or 10 months, then that may not really be a good reason to keep them in a 24-hour level of care.

Q. Why is that?

A. Well, you can't keep people indefinitely in a 24-hour monitored situation just because someday down the road they might relapse. That wouldn't be good clinical treatment.

Q. Turning your attention now to page 36 at the top of the page.

A. (Witness examines document.) Yes.

Q. It reads (reading):

> "The factors leading to admission cannot be safely, efficiently, or effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors."

This provision has the language "acute changes" in it again; is that right?

A. Yes.

Q. And was it left in in this guideline for the same reasons that you explained it was left in the residential guidelines for mental health in 2017?

A. Yes.

Q. Now looking at the rehabilitation residential continued service criteria also on page 36.

A. (Witness examines document.) I'm there.

Q. And specifically looking at the second bullet point where it says (reading):

"Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following..."

And then there's three different provisions there?

A. Yes.

Q. Are those the same provisions we saw in the mental health guideline?

A. Yes, they are.

Q. Now, we just went through a variety of sections of the Level of Care Guidelines for 2017. Are you familiar with TMS?

A. Yes.

Q. What is TMS?

A. Transcranial magnetic stimulation is a treatment involving applying multiple magnets to a person's head for the treatment of treatment-resistant depression.

Q. When UBH is evaluating whether services for TMS are covered under a plan, does it use any of the guidelines that we just went through?

A. There's a separate guideline for TMS.

Q. And is that one that we didn't go through today?

A. Correct.

Q. Are you familiar with ABA treatment?

A. Yes.

Q. What is that?

A. That's Applied Behavioral Analysis, which is a technique for treating individuals with autism.

Q. When UBH is making a coverage decision on whether ABA services are going to be covered under a plan, does it use any of the guidelines that we've gone through today?

A. No. It has its own separate guideline.

Q. Let's move along to 2011 if we can. That would be Exhibit 1.

A. (Witness examines document.)

Q. Dr. Martorana, are you familiar with what has already been admitted into evidence as Exhibit 1?

A. Yes.

Q. What is it?

A. This is the UBH 2011 Level of Care Guidelines.

Q. If I can direct your attention to page 5, please, of Exhibit 1.

A. (Witness examines document.) Yes.

Q. What begins on this page?

A. Oh, sorry. Page 5 is the common criteria.

Q. And if I can direct your attention to paragraph 2 here.

A. Yes.

Q. What is the purpose of paragraph 2 in these common criteria in 2011?

A. Well, this sets out the -- what is required for the

provider to gather in order to make an initial evaluation, diagnosis, and initial treatment plan, which then they would present to us for purposes of authorizing care.

Q. Do these criteria here in paragraph 2 take into account comorbid conditions?

A. Yes.

Q. Where?

A. Item D, "The member's current and past medical and psychiatric histories, including history of substance use," would encompass comorbid and co-occurring conditions.

Q. When we were looking at the 2017 guidelines, you testified about a clinical best practices section in the 2017 guidelines. Do you remember that?

A. Yes.

Q. Do the 2011 guidelines include a clinical best practices section?

A. No. They put it in the common criteria at this point in time.

Q. And when you say that, are you referring to paragraph 2?

A. Yes.

Q. If you can direct your attention now to paragraph 4 of the common criteria.

A. Yes.

Q. It reads (reading):

"The member's current condition can be most

efficiently and effectively treated in the proposed level of care."

What does the term "current condition" mean in that sentence?

A. That means the symptoms that the member is bringing to treatment, those that cause him distress and wants to be addressed in the context of looking at all the factors that led to this point in time with this particular individual.

Q. Does the term "current condition" in paragraph 4 include only crisis?

A. No.

Q. Looking at paragraph 5 now, it reads (reading):

"The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made."

Does "current condition" have the same meaning as you just described for paragraph 4?

A. Yes.

Q. What is the purpose of the requirement that's set forth in paragraph 5 of this guideline?

A. Well, this is taking the clinical thinking through answering the question of whether the member's condition can be treated safely and effectively in a lower level of care, and it

adds in the part about even when there's been treatment and plan modifications and addressing the issues that may be interfering with improvement.

Q. Are you familiar with the term "fail first"?

A. I am.

Q. What does "fail first" mean?

A. "Fail first" is a term describing conditions for coverage which require failure at a lower level of care or at a less expensive level of care -- less expensive treatment.

Q. Is paragraph 5 a fail first provision?

A. No, it's not.

Q. And why is that?

A. Because this is setting out a condition that would cause someone to approve the care. So if you're -- if you have a condition that's severe and they even try to do this and still fail to improve your condition despite all these efforts, then that's a good reason to authorize the level of care.

Q. Turning now to paragraph 6, please, it reads (reading):

> "There must be a reasonable expectation that essential and appropriate services will improve the member's presenting problems within a reasonable period of time. Improvement in this context is measured by weighing the effectiveness of treatment against the evidence that the member's condition will deteriorate if treatment is discontinued in the current level of care. Improvement

must also be understood within the framework of the member's broader recovery goals."

What does it mean to consider improvement in the framework of the member's broader recovery goals?

A. It's similar to the language we saw elsewhere, although we're still coming into the era of consumer focus treatment, so this only mentions recovery goals here. You're talking about basically what does the member want out of treatment and focusing in on what the member is thinking.

Q. There's a reference here to "essential and appropriate services." Is that something different than what we saw in the 2017 guidelines?

A. Yeah. Those are different words, yes.

Q. What do those terms mean?

A. Well, "appropriate" I believe is equivalent to "effective" in that it's known that the treatment matches the diagnosis and other aspects of the member's individualized -- individual condition. "Essential" means that they're necessary.

Q. Under this provision paragraph 6, what does it mean to improve?

A. Well, it talks about -- it has language about determining whether the member might deteriorate if the current treatment was withdrawn. So that's one definition of "improvement" that's mentioned here.

And then there's the reasonable expectation that the

member will -- well, it just says "improve," so it doesn't define it further than that like it does in the other language we've looked at.

Q. Would maintaining a level of functioning -- I'll withdraw that question.

Would maintaining a level of functioning be something that is considered part of improvement in paragraph 6?

A. Yes. That's the part about having evidence that the member might deteriorate if the treatment is withdrawn. That's another way of describing maintenance treatment.

Q. There's a reference here to improvement within a reasonable period of time. Does that phrase "reasonable period of time" have the same meaning you've discussed already with respect to 2017 guidelines?

A. Yes.

Q. There's also use of the term "in this context." Do you see where that is, "improvement in this context"?

A. Yes.

Q. What does "in this context" refer to in this paragraph?

A. It references the first sentence about having expectation of improvement.

Q. Does this paragraph in the 2011 guidelines require continuous improvement in order to remain in a level of care?

A. No.

Q. Does it mean that once the presenting symptoms are

improved, no care is covered?

A. No.

Q. If you can turn to paragraph 7, please. It's on page 6 of Exhibit 1.

A. (Witness examines document.)

Q. It reads (reading):

"The goal of treatment is to improve the member's presenting symptoms to the point that treatment in the current level of care is no longer required."

Why is that the goal of treatment?

A. Again, with the principle that being in a least restrictive level of care is desirable, then we would expect that the goal of treatment -- the primary goal of treatment would be to improve the member's condition so they can be in a less restrictive level of care.

Q. And have you seen that in external sources?

A. Yes.

Q. What external sources have you seen that in?

A. We saw that in the Medicare guidelines, and I've seen it in ASAM as well.

Q. Turning to paragraph 8, please.

A. Yes.

Q. It reads (reading):

"Treatment is not primarily for the purpose of providing respite for the family, increasing the member's

social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition."

What does this language mean?

A. That -- that describes an exclusion for treatment that's -- and the keyword here is "primarily." So if the focus of treatment has to do with someone being sentenced to a residential treatment program, as an example, instead of going to jail and they otherwise wouldn't need this treatment, then that would be -- that would be an exclusion.

Antisocial behavior similarly is often mandated to residential treatment in order to, you know, keep them out of the prisons, for instance, and manage them over a long period of time.

Q. Do patients who need treatment for behavioral health issues sometimes have antisocial or legal problems?

A. Right, but then that wouldn't be the primary purpose of the treatment.

Q. What wouldn't be the primary purpose of the treatment?

A. Just addressing the antisocial behavior. The primary purpose would be to treat the psychiatric condition that may manifest itself as antisocial behavior.

Q. Now, the 2011 guidelines didn't have admission criteria and continued service criteria and discharge criteria all together; is that correct?

A. Right.

Q. Okay. So I'm going to direct you to page 78 of the 2011 guidelines.

A. (Witness examines document.) Okay.

Q. And what is that on page 78?

A. This is the continued service criteria.

Q. Looking at paragraph 2, Dr. Martorana, it reads (reading):

"The member continues to present with symptoms and/or history that demonstrate a significant likelihood of deterioration in functioning or relapse if transitioned to a less intensive level of care or, in the case of outpatient care, is discharged."

What does this provision mean?

A. Well, it has the same intent as the language we've already seen, so one way to continue authorization at a level of care is that the member still has the symptoms that got them into it in the first place, or that we understand that they -- they could -- that there's a good likelihood that if withdrawn, they'll deteriorate.

Q. What does it mean to have a significant likelihood of deterioration in function or relapse?

A. Well, I think as we alluded to earlier, I mean, there's -- mental health and substance use conditions have a high likelihood of relapse, and so the idea being that there's a clinical judgment about is this person really -- he's about to

relapse or it's imminent or immediate, or is this something theoretical for down the road that there's a good chance in months to years that they will. So trying to distinguish that in terms of deciding on a current level of care.

Q. Looking at paragraph 4 of the continued service criteria, it reads (reading):

"The member is actively participating in treatment or is reasonably likely to adhere after an initial period of stabilization and/or motivational support."

What does this mean?

A. So as a condition of treatment, the member is participating so they're getting something out of the care and in a situation where they're not right now, that there are efforts to get them to participate and engage in the treatment.

Q. And why is that something that's required for continued service criteria in the 2011 guidelines?

A. Well, it would be an indication that treatment is occurring or about to occur that will improve the member's condition. So that there's some level of active treatment happening.

Q. Looking at paragraph 8, it reads (reading):

"Measurable and realistic progress has occurred or there is clear and convincing evidence that continued treatment at this level is required to prevent acute deterioration or exacerbation that would then require a

higher level of care. Lack of progress is being addressed by an appropriate change in the treatment plan or other intervention to engage the member."

What is "measurable and realistic progress"?

A. Again, it's related to language we've talked about before where you have a treatment plan that sets out goals and measurable improvement in a -- reasonable and measurable improvement in a certain space of time. So that would be what that refers to here.

Q. And then it says (reading):

"Measurable and realistic progress has occurred or there is clear and compelling evidence that continued treatment at this level of care is required to prevent acute deterioration or exacerbation that would then require a higher level of care."

What does "clear and compelling evidence" refer to?

A. Again, that there's been some indication -- and I think I gave some examples before, you know, someone's in a 24-hour level of care and they have a long history of not functioning well outside of structure like that, or they've tried them on a pass and they've demonstrated clearly that they continue to need the structure. So -- and, that, again, is that the evidence is not just theoretical; that, yeah, we know that this illness, you know, tends to relapse but that this person, you know, with all we know about him and his history and his

current condition is likely to relapse.

Q. Now, was "clear and compelling evidence," that language, taken out of the guidelines after 2011?

A. Yes, it was.

Q. In your experience and your opinion, were the guidelines more restrictive in 2011 because they included that term as opposed to later years?

A. No. The same clinical judgment applied when we were getting the clinical information from the provider and we made the same clinical judgments.

Q. Let's turn to the 2012 guidelines, Exhibit 2.

A. (Witness examines document.)

Q. And if I can direct your attention to pages 6 and 7, Dr. Martorana.

A. Yes.

Q. Are these the common criteria for the 2012 Level of Care Guidelines?

A. They are.

Q. And are these similar in format to 2011 in that common criteria or separate and continued service criteria are somewhere else in the guidelines?

A. That's correct, yes.

Q. And also the clinical best practices section that we looked at for the later years, is that something that is included in the common criteria?

A. Yes.

Q. Where is it in the common criteria for 2012?

A. Mostly in Number 2 where it discusses what's expected for thorough initial evaluation so that we can make a determination of coverage.

Q. And do the items listed in Number 2 take into account comorbid and co-occurring conditions?

A. Yes, it does.

Q. Where is that?

A. Let's see, now it's letter C, so it talks about the psychiatric medical history, substance abuse history, prior history of treatment. All would fall under that category.

Q. If you can look at paragraph 6, please, of the 2012 common criteria on page 7.

A. (Witness examines document.)

Q. It reads (reading):

> "There must be a reasonable expectation that essential and appropriate services will improve the member's presenting problems within a reasonable period of time. Improvement of the member's condition is indicated by the reduction or control of the acute symptoms that necessitated treatment in a level of care. Improvement in this context is measured by weighing the effectiveness of treatment against the evidence that the member's condition will deteriorate if treatment is discontinued in the

current level of care. Improvement must also be understood within the framework of the member's broader recovery goals."

Does your earlier discussion about what it means for there to be a reasonable expectation that services will improve a member's presenting problems in a reasonable period of time in the context of other Level of Care Guidelines apply here as well.

A. Yes.

Q. And the sentence that reads -- it's the second sentence of paragraph 6 -- "Improvement of the member's condition is indicated by the reduction or control of the acute symptoms that necessitated treatment in a level of care," what does that mean?

A. That's one indication of improvement according to this criteria, and so you would be looking at the symptoms that brought them into treatment that required this level of care, and you want to see some reduction in the symptomatology. That would be one way to define "improvement."

Q. And in this paragraph is improvement only indicated by a reduction or control of the acute symptoms that necessitated treatment in a level of care?

A. No. As in other language we've seen that's similar, improvement is also considered when the member is likely to deteriorate if not for this level of care or this treatment

plan.

Q. If you can look at paragraph 7, please.

A. (Witness examines document.) Yes.

Q. It reads (reading):

"The goal of treatment is to improve the member's presenting symptoms to the point that treatment and the current level of care is no longer required."

Have we seen this language before and discussed it?

A. Yes.

Q. And as we've discussed, does this mean that once the presenting symptoms are improved, no care is covered?

A. That's not what this says, no.

Q. And does this provision mean that coverage is provided only for crises?

A. No.

Q. Looking at paragraph 8, please, of these common criteria.

A. (Witness examines document.)

Q. It reads (reading):

"Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition."

Is this language the same language we discussed in 2011 common criteria?

A. Yes.

Q. Looking at paragraph 10, please.

A. (Witness examines document.)

Q. It reads (reading):

"The treatment plan stems from the member's presenting condition and clearly documents realistic and measurable treatment goals as well as the treatments that will be used to achieve the goals of treatment. The treatment plan also considers the following..."

The section that I just read, what does that mean?

A. This, again, highlights what basic good clinical treatment is in regard to the treatment plan so that a good treatment plan would be taking into account the member's presenting condition and the factors that require this level of care, setting specific goals for improvement, they're measurable and specific interventions, and then would obviously adjust them as time went on if the member improved, didn't improve, or got worse.

Q. Does this guideline disallow inclusion of nonacute, nonpresenting chronic conditions in the treatment plan?

A. No. Good clinical judgment and treatment planning includes all the factors that may have bearing on the member's condition and the treatment of the condition. So you would treat someone differently who's got an acute exacerbation of a chronic illness versus just an acute set of symptoms.

Q. Turning to the continued service criteria for 2012 on page 82, please.

A. (Witness examines document.)

THE COURT: Find a space. It's 4:00 o'clock.

MS. ROMANO: Did you say "Find a space"?

THE COURT: Yes.

MS. ROMANO: I've got two paragraphs here, and then perhaps we end before we go into 2013?

THE COURT: Great.

MS. ROMANO: Okay.

THE WITNESS: I'm sorry. What page are we on?

BY MS. ROMANO:

Q. Yes. Page 82.

A. (Witness examines document.)

Q. If you can take a look -- well, are these the continued service criteria for 2012?

A. Yes, they are.

Q. Directing your attention to paragraph 5, please, it reads (reading):

"There continues to be evidence that the member is receiving active treatment and there continues to be a reasonable expectation that the member's condition will improve further. Lack of progress is being addressed by an appropriate change in the member's treatment plan and/or an intervention to engage the member in treatment."

What does this paragraph mean?

A. So it allows the expectation of good clinical treatment, that active treatment is occurring, that they're getting treatment that's expected to improve their condition; and if they're not, that the treatment plan is being changed and modified to address all that.

Q. What does "improvement" or the word "improve" mean in this paragraph?

A. That would mean that the member's -- the problems that have been identified have decreased in a measurable fashion.

Q. Would prevention of deterioration be a part of the consideration here as well?

A. Yes.

Q. And if you can turn to paragraph -- or look at paragraph 6, please.

A. That's where that is, right, what you just said.

Q. If you could look at paragraph 6, please, it says (reading):

"The member's current symptoms and/or history provide evidence that relapse or a significant deterioration in functioning would be imminent if the member was transitioned to a lower level of care in the case of outpatient care" -- excuse me -- "or, in the case of outpatient care, was discharged."

And I think I just cut you off, Dr. Martorana. You said

something about, "Well, that's in that paragraph." So let me ask you. What did you mean by that?

A. Well, you were talking about maintaining someone when there's an indication that they may deteriorate without the level of care, and that was in 6 but not in 5 that we were starting to look at.

Q. Right. And paragraph 6 includes the word "imminent," that "Significant deterioration in functioning would be imminent if the member was transitioned to a lower level of care or, in the case of outpatient care, was discharged." What does the word "imminent" mean there?

A. It means in a short amount of time.

Q. And why is the word "imminent" included there?

A. As we discussed before, there's -- relapse is a common feature of psychiatric and substance abuse treatment, so there's an expectation that there's a high likelihood that someone will relapse at some point in time. So -- but if you're making a level-of-care determination that continued care must be in this level of care, then really the risk should be near time rather than somewhere down the road and an indefinite time.

MS. ROMANO: This is a good spot for a break, Your Honor.

THE COURT: Great. Anything we should talk about before we adjourn for the day?

MS. ROMANO: (Shakes head.)

THE COURT: Okay, great.

All right. See you tomorrow.

MS. ROMANO: Thank you.

(Proceedings adjourned at 4:07 p.m.)

(Proceedings to resume on Wednesday, October 25, 2017.)

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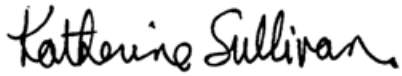
CERTIFICATE OF REPORTERS

We certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

DATE: Tuesday, October 24, 2017



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